Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Annex A-3

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Pertrochanteric Fractures

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	

CLINICAL FEATURES	**Yes**
Stable fracture of the intertrochanteric area, classified as Type A1 fracture	
Unstable/comminuted pertrochanteric fracture classified as Type A2 or A3 fracture	

Attested by Attending Orthopedic Surgeon:

_____
Printed name and signature

Note: There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.

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Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Pertrochanteric Fractures

DATE OF REQUEST:
This is to request approval for provision of services under the Z benefit package for _____ in _____ (NAME OF PATIENT) (NAME OF HOSPITAL) under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Fixed Co-pay (indicate amount) Php _____

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon

Certified correct by:
(Printed name and signature) Executive Director/Chief of Hospital

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(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION	COMPLIANCE OF REQUIREMENTS
Date received by Local Health Insurance Office (LHIO: _____ Date endorsed to BAS: _____ Date (Approved/Disapproved): _____ Date endorsed to LHIO: _____ Date released to Hospital: _____	☐ APPROVED ☐ DISAPPROVED (State Reason/s) _____ Date endorsed to BAS: _____ Date (Approved/Disapproved) _____ Date endorsed to LHIO: _____ Date released to Hospital: _____

This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.