

Case No.

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION Citystate Centre. 709 Shaw Boulevard. Pasig City



Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444 www.philhealth.gov.ph

						Ar	nnex	A – "	Prosta	ate C
HEALTH CAI	RE PROVIDER (HCI	P)								
ADDRESS OF	F НСР									
	1101									
A. PATIENT	1. Last Name, First N	Name, Middle Na	me, Suffi	X			SEX		□ Fe	male
	2. PhilHealth ID Nu	ımber]-[П		
B. MEMBER	☐ Same as patient (A	Answer the following	only if the	patien	t is a	deper	ndent)		
	1. Last Name, First Name, Middle Name, Suffix									
	2. PhilHealth ID Nu	ımber]-[]						_	
	PRE-A	UTHORIZATIO Prostate Ca		CKLIS	ST	/				
Fulfilled sele	ections criteria						appl	icatio	n —	
ATTESTED B	Y ATTENDING PHY	YSICIAN					(Plac	e a √ i	f YES)
QUALIFICAT		-		7					YES	
	iotherapy for prostate ca	ıncer	37/							
No uncontrolled	l co-morbid conditions									
							(Plac	e a √ i	f YES)
							DATE DONE			
DIAGNOSTIC	.5					YES	8	(mm/	dd/yy	yy)
(T1a-T3c), Tum	or Grade (Gleason's sco	re of 6-9)								
No evidence of : ☐ Bone scan ☐ Pelvic CT/M ☐ PET Scan	metastasis (documented)	by <u>any</u> of the follo	wing):							
	o the patient's chart)									
Conforme by Pati			Certified o	orrec	t bv	Atten	dino	Physic	cian:	
Somomic by I at	one, Guardiani		Serunea C	.01100	y 1	. 100011	g	1 11y 51v		
Printed name and	signature		P	Printed name and signature						-
	U	PhilHealth Accreditatio				-	0-1		-	-





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UNIVERSAL HEALTH CARE

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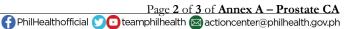
Note:

Once approved, the contracted HCP shall print the approved pre-authorization form and have this signed by the patient or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.









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PRE-AUTHORIZATION REQUEST Prostate Cancer

DATE OF REQUEST (mm/dd/yyyy):												
This is to request approval for provision of services under the Z benefit package for												
in												
(Patient's last, first, suffix, middle name) (Name of HCP) under the terms and conditions as agreed for availment of the Z Benefit Package.												
The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box): Without co-payment With co-payment, for the purpose of:												
Certified correct by:	A	Certified correct by:										
(Printed name and signature)			(Printed name and signature)									
Attending Physician			Executive Director/Chief of Hospital/									
PhilHealth			Medical Director/Medical Center Chief PhilHealth									
Accreditation No.			Accreditation No.									
		Conforme by: (Printed name and signature) Patient										
	(Fo	r PhilH	ealth Use Only)									
□ APPROVED												
□ DISAPPROVED (State reason/s)												
(Printed name and signature)												
Head or authorized representative, Benefits Administration Section (BAS)												
INITIAL APPLICAT		COMPLIANCE TO REQUIREMENTS										
Activity	Initial	Date	□ APPROVED									
Received by LHIO/BAS:			☐ DISAPPROVED (State reason/s)									
Endorsed to BAS												
(if received by LHIO):			(Printed name and signature) Head or authorized BAS representative									
☐ Approved ☐ Disapproved			Activity	Initial	Date							
Released to HCP:			Received by BAS:									
This pre-authorization is valid fo	0)	☐ Approved ☐ Disapproved										
calendar days from date of approval of request.			Released to HCP:									

