

Case No. \_\_\_\_\_

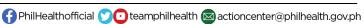
## Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION



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

		Annex "A – TOF"				
HEALTH CA	RE PROVIDER (HCP)					
ADDRESS OF	FHCP					
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix  SEX  Male  Male  □					
	2. PhilHealth ID Number					
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)					
	1. Last Name, First Name, Middle Name, Suffix					
	2. PhilHealth ID Number	-				
Fulfilled selections criteria						
PRE-AUTHORIZATION CHECKLIST  Tetralogy of Fallot Surgery  Place a check mark (✓)						
QUALIFICA'		YES				
Age 1 to 10 year	ars and 364 days	7/				
ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST  Place a check mark (						
QUALIFICA'	ΓIONS	YES				
Tau b. No c. No 2. Check phys No hep No ede	previous cardiac surgery or intervention such as BTS (Blalock assig Shunt) PDA Stenting or residual VSD from previous open heart surgery for total corresical examination: patomegaly or ma lower extremities	ection				
	ital chromosomal abnormalities or other congenital defects, ex (Down's syndrome)	xcept				





Place a check mark (✓)

	1 lace a	clicck mark (*)
DIAGNOSTICS <sup>1</sup>	YES	DATE DONE (mm/dd/yyyy)
Based on the results of 2D Echocardiogram OR, if applicable,		
cardiac catheterization OR CT angiogram: <sup>2</sup>		
a. Confirmed Tetralogy of Fallot OR Confirmed Ventricular		
Septal Defect and pulmonic stenosis, severe (This is similar		
to TOF morphology) <sup>3</sup>	, D	
b. No other associated congenital heart disease (CHD) that		1/1
includes the following:		M \
i. absent pulmonic valve		
ii. pulmonary valve atresia		
ii. atrioventricular septal defect (AVSD)		<b>11</b> /
c. Confluent and adequate pulmonary artery sizes OR		7/
acceptable pulmonary valve annulus		7/
d. NO major aorto-pulmonary collateral arteries (MAPCA's)	A	//
		/

- Must be done at least within one fiscal (1) year from date of receipt of pre-authorization.
- <sup>2</sup> Attach OFFICIAL 2D ECHO RESULTS in the patient's chart
- <sup>3</sup> By morphologic classification of TOF, the components of TOF, which include a VSD with pulmonic stenosis, infundibulovalvar, may be of the same nature as the acyanotic VSD with pulmonic stenosis. The difference lie in the degree of overriding and dilatation of the aorta which is absent in VSD with PS. As such, clinical presentation will be cyanosis in TOF and acyanosis in the pure VSD with PS types. Despite the difference in morphologic components and clinical presentation, the surgical procedure of TOTAL CORRECTION will be the same for both. This includes:
  - i. VSD Patch Closure
  - ii. + RVOT repair with or without patch OR
  - iii. + infundibulectomy of the infundibular muscle

Certified correct by:	Conforme by:
(Printed name and signature)	(Printed name and signature)
Attending Pediatric Cardiologist	Parent/Guardian
PhilHealth Accreditation No.	

## Note:

Once approved, the contracted HCP shall print the approved pre-authorization form and have this signed by the patient, parent 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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UNIVERSAL HEALTH CARE

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## PRE-AUTHORIZATION REQUEST **Tetralogy of Fallot Surgery**

DATE OF REQUEST (mm/c	DATE OF REQUEST (mm/dd/yyyy):							
This is to request approval for provision of services under the Z benefit package for								
		1	n					
(Patient's last, first, suffix, mi	,		(Name of HCI	,				
under the terms and condition	s as agre	ed for av	ailment of the Z Benefit Packag	ge.				
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:			Certified correct by:					
Germied correct by.			Gertified coffeet by.					
(Printed name and sig	gnature)		(Printed name and signature)					
Please tick appropriate box			Executive Director/Chief of Hospital/					
☐ Chair, Department of Pedi	atric Car	diology	Medical Director/ Medical Center Chief					
☐ Chief, Division of Pediatric								
PhilHealth Accreditation No.			PhilHealth Accreditation No.					
			Conformalay					
			Conforme by:					
			(Printed name and signature)					
			Patient					
			Patient					
	/Ea	Db:11 Lo.	alkla Llas Oralis					
	(го	r Philifie	alth Use Only)					
□ APPROVED	/ >							
☐ DISAPPROVED (State re	ason/s) <sub>.</sub>							
(Printed name and signatur								
Head or authorized representative, I	Benefits	Administ	tration Section (BAS)					
INITIAL APPLICAT	ΓΙΟΝ		COMPLIANCE TO REQ	UIREME	NTS			
Activity	Initial	Date	□ APPROVED					
Received by LHIO/BAS:			☐ DISAPPROVED (State reaso	on/s)				
Endorsed to BAS								
(if received by LHIO):		(Printed name and signature)						
☐ Approved ☐ Disapproved			Head or authorized BAS ref <b>Activity</b>	Initial	Date			
Released to HCP:			Received by BAS:					
This pre-authorization is valid for one hundred			☐ Approved ☐ Disapproved					
eighty (180) calendar days from date of approval			**					
of manager		Released to HCP:						

