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

PHILHEALTH CIRCULAR
No. 048 s. 2012

TO : ALL PHILHEALTH-CONTRACTED HEALTHCARE PROVIDERS FOR THE Z BENEFIT PACKAGE

SUBJECT : IMPLEMENTING GUIDELINES ON THE Z BENEFIT PACKAGE

I. BACKGROUND

A new case type Z under the PhilHealth classification of illnesses covers for a unique set of catastrophic illnesses defined in PhilHealth Circular No. 29 s. 2012; and a corresponding benefit package called the Z Benefit Package was developed (PhilHealth Circular No. 30 s.2012). This package aims to increase financial risk protection for PhilHealth members, especially the underprivileged, through the delivery of quality care using cost-efficient interventions that are based on approved clinical protocols and guidelines. It also aims to increase awareness among people at-risk and enabling healthcare providers to capture them at the most early stage of the illness to ensure better survival.

The Z benefit package defines a new strategic approach to paying for "catastrophic" illnesses because reimbursements are scheduled according to delivery of the mandatory services as provided in the protocols and/or guidelines. The payment scheme not only eases the process of reimbursement for these illnesses with repetitive procedures, but ensures that patients are given the acceptable standards of care at the appropriate time. Further, the package was designed to strengthen doctor-patient relationship in healthcare delivery. It recognizes the importance of patient involvement and has therefore integrated in its process a mechanism of evaluating delivery of care through patient feedback. To minimize patients being lost to follow-up who are stricken with these illnesses as a consequence of several factors, the process using the Z Benefit Information and Tracking System (ZBITS) shall be employed to monitor these patients, while empowering them to be actively involved in their care.

Owing to the multi-disciplinary - interdisciplinary nature of care needed for case type Z illnesses, the package shall be implemented only by hospitals contracted by PhilHealth to provide the mandatory services. PhilHealth has initially contracted 22 government hospitals nationwide to implement the package.

II. OBJECTIVES

This Circular will:

1. Provide a procedure for filing of case type Z claims for reimbursement;
2. Describe the mechanism of establishing a patient information and tracking system that will monitor delivery of care and patient adherence to treatment;
3. Establish a gatekeeping mechanism through pre-authorization, which ensures that patients are screened accordingly and assured of the treatment based on approved protocols.

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MA. TERESA A. QUIAOIT
A.O. IV, Chief-RELMS
Date: 10/3/12
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All patients who did not qualify during the pre-authorization stage for case type Z may still avail of the other PhilHealth benefits under a different payment scheme, such as case rates and fee-for-service.

III. GUIDELINES FOR AVAILING OF THE BENEFIT

Only hospitals contracted by PhilHealth to provide services for case type Z may file a claim for the Z Benefit Package. Non-contracted hospitals providing service to patients with case type Z illness who are currently availing of the Z-Benefit Package shall not be reimbursed for services stipulated in the mandatory services under PhilHealth Circular No. 30, s. 2012. These non-contracted hospitals shall check with PhilHealth if patient is already registered under the Z Benefit Package and in such case, advise the member to inform their contracted hospital of any request for transfer. Any transfer to a non-contracted hospital shall mean a waiver of the patient's Z benefit, such that any claim filed in the non-contracted hospital for any type Z related services from registry of that Z illness to the Z benefit package shall not be reimbursed by PhilHealth in the next three (3) years.

A. ELIGIBILITY CHECK

All contracted hospitals shall follow their existing process of checking eligbility requirements for availment of PhilHealth benefits, to determine:

Qualified premium contributions; Beginning January 1, 2013, the 3-year lock in membership with continuous premium payment shall apply (refer to PhilHealth Circular No. 029, series of 2012)

- Principal member and their qualified dependents,
- Minimum of one day remaining balance from the 45-day annual benefit limit

For contracted hospitals with health information system capable of on-line checking, eligibility check may be done thru the e-claims system

However, owing to the special nature of the benefit, an additional eligibility rule shall be required:

1. Only newly diagnosed cases are eligible, hence, eligibility check shall require retrieval of the member's claims history in the past two years (thru the N-claims confinement journal) in order to establish compliance with this policy. A newly diagnosed case is defined as a patient who has not received any of the mandatory services and/or other services for the specific illness included in the Case Type Z Benefit Package, except for kidney transplant patients.

While this requirement may not yet be checked on-line, requests to check eligibility may be done at the Benefits Administration Section (BAS) in the PhilHealth Regional Offices.

The BAS shall check compliance with all eligibility requirements and issue a certification of eligibility. This certificate shall be sent back to the contracted hospital preferably within two (2) working days from date of receipt of request of certification of eligibility.

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Date: 10/7/12
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Eligibility checking shall be done only once throughout the entire availment of the benefit, e.g., for acute lmphoblastic leukemia which will be paid in three (3) tranches for a period of three (3) years, the eligibility check shall be done only on the first year of the 3 years prior to the pre-authorization.

B. PRE-AUTHORIZATION

Once the member has complied with all the eligibility rules as prescribed, the contracted hospital shall proceed with the conduct of services required for pre-authorization. The hospital shall submit a request for pre-authorization approval to the PhilHealth Regional Office-Benefits Administration Section (PRO-BAS). To facilitate the request, a pre-authorization checklist (Annex "A") for each of the case type Z illnesses shall be provided to the PRO-BAS. The list shall be checked against all supporting documents submitted by the hospital, including the ME Form (Annex "B"), which serves as a compliance validation to the selections criteria for pre-authorization.

If the member/patient met the selections criteria for pre-authorization, the BAS Head shall provide his stamped approval or his/her signature over printed name on the pre-authorization request, with the date of approval, and sends this back to the hospital immediately, preferably on the same day the request was received by the BAS. The BAS shall be given a maximum of two working (2) days to send back the approval/disapproval notice. If the request was sent on a weekend, the hospital must be informed immediately on the first working day of the following week. In the event that a pre-authorization request is required for emergency cases, such as cadaveric kidney transplantation, and the request falls on a weekend or holiday, the BAS Head shall make his/her contact information such as official mobile number and email available to the contracted hospital for approval/disapproval of request for pre-authorization. However, the contracted hospital shall still submit the pre-authorization request form to the BAS immediately on the following working day, for the approval/disapproval of said request.

C. REGISTERING PATIENTS IN THE Z BENEFIT INFORMATION TRACKING SYSTEM (ZBITS)

All contracted hospitals through their ZBITS coordinator shall be required to encode all patients with diagnosed case type Z illness in the ZBITS. These data shall be submitted to the reference hospital for consolidation. All data elements in the system must be completely filled out and updated regularly. A separate issuance shall be issued for details of the ZBITS process.

D. FILING OF CLAIMS BY CONTRACTED HOSPITALS

After receipt of the pre-authorization approval and prior to filing of a claim, all contracted hospitals must render all mandatory and other services as prescribed in the approved protocols.

To file a claim, the contracted hospital shall accomplish the following and shall submit all claims to the PRO BAS:

1. The hospital shall submit claim application per completed tranche using the manual or eclaims system.
2. The hospital shall be required to submit an accomplished PhilHealth CF 2 (for manual) or Module 2 (for eclaims) as follows:
   a. Part 1
      - Fill out # s 1-10
      - # 11 a to d need not be filled out
      - For # 11e (Benefit Package) indicate the tranche amount under the PhilHealth Benefit column.
      - # 12, Indicate **Case Type Z**
      - # 13, indicate the corresponding Benefit Package Code (refer to PhilHealth Circular # 30 s. 2012 for the codes)
      - # 14, primary condition is the case type Z illness
      - # 15, similar to # 14
      - # 16a, indicate PAY TO HOSPITAL
      - # 16 c,d,e need not be filled out

The RVS codes for all procedures included in the mandatory services and/or other services under a Case Type Z are locked to the Package Code. The lock ensures that for any claim filed by the same patient/member done in a non-contracted hospital using any of the pre-identified RVS codes relative to the treatment of the particular case type Z illness shall be denied by the system.

f. PhilHealth Benefit
Z0011

- # 16f, indicate the Benefit Package Code and the tranche payment being filed, e.g., acute lymphocytic leukemia, 1st tranche payment

b. Part II and III need not be filled out; drugs/medicines that are part of the mandatory services are already included in the checklist. Parts IV and V must be filled out.

3. Hospitals shall file claims according to existing policies and in line with the filing schedule stated in Philhealth Circular No. 30 s. 2012.
4. Rules on late filing shall still apply.
5. Documents to be submitted to the PRO:
   - Accomplished PHIC Claim Form 2 or Module 2 for eclaims
   - Checklist Form of mandatory services (with tick boxes)and corresponding dates when the service was given
   - Results of diagnostics, laboratory tests
   - Photocopy of the ME Form signed and dated by the patient/member and attending doctor upon availment of the Case Type Z Benefit

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1. The hospital shall submit claim application per completed tranche using the manual or eclaims system.
2. The hospital shall be required to submit an accomplished PhilHealth CF 2 (for manual) or Module 2 (for eclaims) as follows:
   a. Part 1
      - Fill out # s 1-10
      - # 11 a to d need not be filled out
      - For # 11e (Benefit Package) indicate the tranche amount under the PhilHealth Benefit column.
      - # 12, Indicate **Case Type Z**
      - # 13, indicate the corresponding Benefit Package Code (refer to PhilHealth Circular # 30 s. 2012 for the codes)
      - # 14, primary condition is the case type Z illness
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      - # 16a, indicate PAY TO HOSPITAL
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The RVS codes for all procedures included in the mandatory services and/or other services under a Case Type Z are locked to the Package Code. The lock ensures that for any claim filed by the same patient/member done in a non-contracted hospital using any of the pre-identified RVS codes relative to the treatment of the particular case type Z illness shall be denied by the system.

PhilHealth Benefit
Z0011

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   - Accomplished PHIC Claim Form 2 or Module 2 for eclaims
   - Checklist Form of mandatory services (with tick boxes)and corresponding dates when the service was given
   - Results of diagnostics, laboratory tests
   - Photocopy of the ME Form signed and dated by the patient/member and attending doctor upon availment of the Case Type Z Benefit

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Date: 10/3/12
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- Photocopy of MOA, if applicable, for services done outside of the contracted hospital.
- Patient satisfaction mark (found in the Z satisfaction questionnaire which is encoded in the ZBITS)
- Proof of qualifying contribution

E. EVALUATION OF CLAIM

1. A filed claim shall undergo medical evaluation by the BAS. Since one claim covers for a series of mandatory services done over a period of time, a separate checklist for the mandatory services and other services shall be submitted by the hospital. During the evaluation, the evaluator checks for the list of services corresponding to the requested tranche and the patient must conform to each through a signature, signifying that he/she received the service. The filed claim may be appreciated using the e-claims system vis-à-vis the ZBITS or paper evaluation.

Example:
CHECKLIST for FIRST TRANCHE (ALL)

CHEMOTHERAPY	STATUS	DATES	Attested by Attending Physician and Patient/Guardian
a) vincristine	√	6/23/2012	
b) L-asparaginase	√	6/24/2012	
c) methotrexate (IV, IT and oral),	√	6/24/2012	
d) 6-mercaptopurine	√	6/26/2012	
e) cyclophosphamide	√		
f) cytarabine (IV and IT),	√		
g) etoposide,	√		
h) doxorubicin,	√		
i) ondansetron,	√		
j) tramadol,	√		
k) bone marrow examination (with attached result)	√		
l) immunophenotyping (with attached result)	√		

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Date: 10/31/12
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2. There shall be no Return to Hospital (RTH) claims for the Z Benefit. The ZBITS/paper checklist contains all the mandatory services that must be given to the patient and this shall be validated with all supporting documents attached. Supporting documents shall include results for all laboratory and diagnostic work-ups. The other services in the checklist may or may not be given as scheduled.

3. All claims shall be processed by PhilHealth within 30 days from receipt of claim.

4. For all good claims filed on FIRST tranche, 5 days shall automatically be deducted from the required remaining 45 day annual benefit limit. There shall be no more deductions from the 45 days for the succeeding tranches.

5. Claims shall be denied payment in the following instances:
   - If a mandatory service was not given.
   - If initials of the member/patient are missing in the checklist at any one time during the delivery of the service;
   - If there is no PS mark; or
   - Late filing

All denied claims may still be applied for motion for reconsideration (PHIC Circular No. 3, s. 2008 for Motion for Reconsideration)

F. REIMBURSEMENT

For the existing system, claims shall be encoded into the N-claims for payment processing until such time that electronic adjudication is implemented All vouchers shall be PAID TO HOSPITAL. There shall be no direct filing of members. The amount is fixed per illness and per tranche payments. (Refer to PhilHealth Circular No. 030, series of 2012 for the rates and amount per tranche.)

G. MONITORING AND EVALUATION

Reference hospitals shall consolidate all data and generate quarterly and annual reports. This shall be the basis for incentive computations, current and projected drug/laboratory utilization, patient adherence, and assessment of health outcomes that shall be prepared.

All contracted hospitals shall be subject to monitoring rules of PhilHealth as stipulated in both the Performance Commitment and the Z-Benefit Contracts. Any violation noted and validated from monitoring activities shall be a ground for sanctions and penalties as provided in both contracts.

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, CHAIRMAN
Date: 10/31/17
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IV. ATTACHMENTS:

1. Certificate of Eligibility
2. Pre-authorization Request & Checklist (Annex "A")
3. ME Form (to be reproduced by the hospital) (Annex "B")
4. Checklist form of mandatory services (Annex "C")
5. Z- satisfaction questionnaire (to be reproduced by hospital) (annex "D")
6. Original or certified true copy of approved pre-authorization request & checklist

V. EFFECTIVITY

This guideline shall take effect for pre-authorizations approved beginning June 21, 2012.

DR. EDUARDO P. BANZON
President and CEO
Date signed 9/19/12

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief-RELMS
Date: 10/11/12
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ANNEX "A" – (ALL)

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

DATE _____

NAME OF HOSPITAL _____

NAME OF PATIENT _____

PhilHealth ID Number _____

PRE-AUTHORIZATION CHECKLIST (ACUTE LYMPHOBLASTIC LEUKEMIA)

(Place a ✓or NA)

QUALIFICATIONS	Yes	Attested by Attending MD
1. Age (1-10)		
2. No CNS involvement based on CSF cell count/diff count		
3. If male, no testicular involvement		

DIAGNOSTICS	Yes	Date done	Attested by Attending MD
White blood cell count <50,000/µL			
Immunophenotype Result (precursor B type)			

PRE-AUTHORIZATION REQUEST

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: ☐ FIXED CO-PAY ☐ NBB

Requested by:

_____
Printed Name & Signature
Attending Physician

Noted by:

_____
Printed Name & Signature
Executive Director/Chief of Hospital

(For Philhealth Use Only)

☐ APPROVED

☐ DISAPPROVED

_____

(Signature over Printed Name)

Head, Benefits Administration Section

DATE: _____

ANNEX "A" – (BREAST CA)

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

DATE _____

NAME OF HOSPITAL _____

NAME OF PATIENT _____

PhilHealth ID Number _____

PRE-AUTHORIZATION CHECKLIST (BREAST CANCER)

(Place a ✓or NA)

QUALIFICATIONS	Yes	Attested by Attending MD
1. No previous chemotherapy		
2. No previous radiotherapy		

DIAGNOSTICS (Check one)	Yes	Date done	Attested by Attending MD
Stage:			
Stage 0 TisN0M0			
Stage IA T1N0M0			
Stage IB T0, T1N1M0			
Stage IIA T0, T1N1M0 or T2N0M0			
Stage IIB T2N1M0 or T3N0M0			
Stage IIIA T0, T1, T2N2MO or T3N1N2M0			

PRE-AUTHORIZATION REQUEST

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: ☐ FIXED CO-PAY ☐ NBB

Requested by: Noted by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Chief of Hospital

(For Philhealth Use Only)

☐ APPROVED
☐ DISAPPROVED

_____
(Signature over Printed Name)
Head, Benefits Administration Section
DATE: _____

Annex "A" - KT

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Healthline 441-7442 *www.philhealth.gov.ph*

DATE: _____
NAME OF HOSPITAL, CITY _____
NAME OF PATIENT _____
(Last) (First) (Middle)
PhilHealth ID Number _____

PRE-AUTHORIZATION CHECKLIST (KIDNEY TRANSPLANT)

CONFORME BY PATIENT (Place a ✓or NA)

QUALIFICATIONS	YES	CONFORME
Age >10 and <70 years		
On chronic dialysis because of end stage renal disease except for pre-emptive kidney transplantation		
For Medical Social Service patients, must have a certification from the social service unit of the hospital that patient is eligible for a kidney transplant and they can maintain anti-rejection medicines for the next three (3) years. (Write NA [NOT APPLICABLE] for pay patients)		

ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURGEON (Place a ✓or NA)

QUALIFICATIONS	YES	CONFORME
With irreversible renal disease that progresses to end stage renal disease.		
No previous history of cancer (except basal cell skin cancer), should be HIV negative, Hepatitis B surface antigen negative, and Hepatitis C antibody negative.		
Absence of current severe illness (Congestive heart failure Class 3-4, liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension), chronic lung disease requiring oxygen, etc).		
Absence of the following: hemiparalysis, leg amputation because of peripheral vascular disease, mental incapacity such that informed consent cannot be made, and substance abuse for at least 6 months prior to start of transplant work-up.		
For CMV IgG negative recipient, donor should be CMV IgG negative.		

ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURGEON (Place a ✓or NA)

DIAGNOSTICS	YES	CONFORME
For pre-emptive kidney transplant and diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 20 ml/min /1.73m2		
For pre-emptive kidney transplant and non-diabetic: less than 15 ml/min /1.73m2		
Low risk: a. Primary kidney transplant (no previous solid organ transplant)* a. Historical Past Panel Reactive Antibody (PRA) Class 1 & 2 negative or historical PRA less than or equal to 20% c. No donor specific antibody (DSA) in the potential recipient d. At least 1 HLA-DR match e. Single organ transplant *		

* NO test is required

PRE-AUTHORIZATION REQUEST

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: ☐ PAY ☐ CO-PAY ☐ SERVICE

Requested by:

_____
(Signature over Printed Name)
ATTENDING NEPHROLOGIST OR
TRANSPLANT SURGEON

Noted by: (For SERVICE and CO-PAY ONLY)

_____
(Signature over Printed Name)
Check the appropriate box:
☐ Chair, Department of Adult Nephrology
☐ Chair, Department of Pediatric Nephrology
☐ Chair, Department of Organ Transplantation

(For Philhealth Use Only)

☐ APPROVED

☐ DISAPPROVED

_____
(Signature over Printed Name)
Head, Benefits Administration Section

DATE: _____

ANNEX "A" – (PROSTATE CA)

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

DATE _____
NAME OF HOSPITAL _____
NAME OF PATIENT _____
PhilHealth ID Number _____

PRE-AUTHORIZATION CHECKLIST (PROSTATE CANCER)

(Place a ✓or NA)

QUALIFICATIONS	Yes	Attested by Attending MD
1. Male patients age up to 70 years old		
2. No previous radiotherapy		
1. No uncontrolled co-morbid conditions		

(Place a ✓or NA)

DIAGNOSTICS (check one)	Yes	Date done	Attested by Attending MD
Stage:			
(T1a-T2c), PSA level 10 to 20 ng/ml, Tumor Grade (*Gleason's score of 2-7)*			
Low risk: T1-T2a and Gleason score 2-6, and PSA <10 ng/ml			
Intermediate risk: T2b to T2c, Gleason score of 7, and PSA 10-20 ng/ml			
Localized prostate cancer			
Stage IIB T2N1M0 or T3N0M0			
Stage IIIA T0, T1, T2N2MO or T3N1N2M0			

PRE-AUTHORIZATION REQUEST

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: ☐ FIXED CO-PAY ☐ NBB

Requested by: Noted by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Chief of Hospital

(For Philhealth Use Only)

☐ APPROVED
☐ DISAPPROVED
☐

_____
(Signature over Printed Name)
Head, Benefits Administration Section
DATE: _____

MESSAGE FROM THE PRESIDENT & CEO

To our dear member,

Our warmest greetings from PhilHealth.

We are pleased to share with you our Z benefit package, a package that was created to provide financial risk protection to members like you who are affected by catastrophic conditions that can be financially debilitating. This is why, as your partner in health, we want to be with you at this critical time and take part in your journey towards wellness.

What you're holding now is called the Member Empowerment (ME) Form. As the name suggests, it aims to **empower** you by providing the information that you need to know to adhere to your treatment – the benefits included in this package, treatment choices and options, reminders on your treatment schedule and follow-ups, and your roles and responsibilities as a member. It also leads you to support programs, like education and counselling, and other financial support systems.

Just a friendly reminder: Please remember to complete the ME Form properly to make sure that your claims and reimbursements will be processed efficiently. We'd like to serve you as best as we can.

Sincerely hoping for your speedy recovery and good health,

DR. EDUARDO P. BANZON
President & CEO
Philippine Health Insurance Corporation

MEMBER EMPOWERMENT FORM

Inform, support & empower

Instructions:

1. The healthcare provider shall assist the patient in filling-up the ME form.
2. Legibly print all information provided.
3. For items requiring a "yes" or "no" response, tick appropriately with a check mark (√).
4. Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. The ME form shall be reproduced by the contracted hospital providing specialized care.
6. Duplicate copies of the ME form shall be made available by the contracted hospital—one for the patient and one as file copy of the contracted hospital providing the specialized care.

Note: This ME Form is being translated into Filipino and will be circulated as soon as approved by PhilHealth.

Member/Patient Information	Name of Patient Philhealth No. Current age Birthday Sex Permanent address Telephone/Mobile No. Email address
Clinical Information	Description of condition or diagnosis Treatment Protocol agreed upon with healthcare provider Alternative Protocol/s agreed upon with healthcare provider
Treatment Schedule and Follow-up Visit/s	Date of initial hospital admission (month/day/year) Date/s of succeeding hospital admission/s (month/day/year) Date/s of follow-up visit/s (month/day/year)

	Emergencies (Write exact date/s with the reason or brief description of the nature of the emergency)
Member Education	1. My healthcare provider explained the nature of my condition. Yes ___ No ___ 2. My healthcare provider explained the treatment options. Yes ___ No ___ 3. The possible side effects/adverse effects of treatment were explained to me. Yes___ No___ 4. My healthcare provider explained the mandatory services and other services required for the treatment of my condition. Yes___ No___ 5. I am satisfied with the explanation given to me by my healthcare provider. Yes___ No___ 6. I have been fully informed that I will be cared for by all the pertinent medical specialties (surgery, medical/ pediatric oncology/ nephrology, radio-oncology, and other pertinent specialties as I may need) present in the Philhealth contracted hospital of my choice and that preferring another contracted hospital for the said specialized care will not affect my treatment in any way. Yes___ No ____ 7. My healthcare provider explained the importance of adhering to my treatment schedule. Yes ___ No ___ 8. My healthcare provider gave me the schedule/s of my follow-up visit/s. Yes ___ No ___ 9. My healthcare provider gave me information where to go for financial and other means of support, when needed. Yes ___ No ___ a) Name of government agency (PCSO, PMS, LGU, etc) i. _____ ii. _____ iii. _____ b) Name of non-governmental organization/s

i. _____
ii. _____
iii. _____

c) Name of Patient Support Group/s
i. _____
ii. _____
iii. _____

d) Name of Corporate Foundation/s
i. _____
ii. _____
iii. _____

e) Others (Media, Religious Group/s, Politician/s, etc)
i. _____
ii. _____
iii. _____

10. I have been furnished by my healthcare provider with a list and contact information of other contracted hospitals for the specialized care of my condition.
Yes___ No___

11. I have been fully informed by my healthcare provider of the Philhealth membership policies and benefit availment on the Case Type Z:

a. I fulfill all selections criteria for my condition. Yes___ No ___
b. I understand the "no balance billing" (NBB) policy for sponsored members.
Yes___ No___
c. I understand the fixed co-pay for non-sponsored members.
Yes___ No___
d. Only five (5) days shall be deducted from the 45 days annual benefit limit for the duration of my treatment under the case type Z benefit package.
Yes___ No___
e. I shall update my premium contributions in order to avail the Case Type Z package and other Philhealth benefits.
Yes___ No___

Member Roles & Responsibilities

1. I understand that I am responsible for adhering to my treatment schedule.
Yes___ No___

2. I understand that adherence to my treatment schedule is important in terms of treatment outcomes and a pre-requisite to the full entitlement of the case type Z benefit.
Yes___ No___

	3. I understand that it is my responsibility to follow and comply with all the policies and procedures of Philhealth and the healthcare provider in order to avail of the full case type Z benefit package. In the event that I fail to comply with policies and procedures of Philhealth and the healthcare provider, I waive the privilege of availing the Z benefit. Yes___ No___
Printed Name, Signature, Thumb Print and Date	Signature/Thumb Print of Patient Date (Month/Day/Year) Name of Attending Doctor Signature Date (Month/Day/Year) Witnesses 1. Name of Hospital staff Signature Date (Month/Day/Year) 2. Name of parent/guardian/spouse/next of kin Signature Date (Month/Day/Year)
Contact Philhealth	1. Philhealth Cares 2. Call us at telephone number: 3. Text us: 4. email us:
Consent to Access Patient Record/s	I consent to the examination by Philhealth of my medical records for the sole purpose of verifying the veracity of the Z-claim.
Consent to Enter Medical Data in the Z Benefit Information & Tracking System (ZBITS)	I consent to have my medical data entered electronically in the ZBITS as a requirement for the Case Type Z.
	I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.
Name of Patient, Signature/Thumb Print and Date	Name of Patient Signature/Thumb Print Date (Month/Day/Year)

Name of Patient's Representative, Signature and Date	Name of Patient's Representative Signature Date (Month/Day/Year)
Relationship of the Representative to the Patient	___ Spouse ___ Parent ___ Child ___ Next of Kin/Guardian

Annex "C" -ALL

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Healthline 441-7442 *www.philhealth.gov.ph*

DATE: _____
NAME OF HOSPITAL _____
NAME OF PATIENT _____
PhilHealth ID Number _____

CHECKLIST FOR MANDATORY AND OTHER SERVICES

ACUTE LYMPHOCYTIC LEUKEMIA: TRANCHE

Mandatory and Other Services	Status (place a √ if done or NA)	Dates	Conforme
A.Chemotherapy			
1. Vincristine			
2. L-asparaginase			
3. Methotrexate			
a. IV (intravenous)			
b. IT (intrathecal)			
c. Oral			
4. 6-mercaptopurine			
5. Cyclophosphamide			
6. Cytarabine			
a. IV (intravenous)			
b. IT (intrathecal)			
7. Etoposide			
8. Doxorubicin			
B.Other drugs			
1. Dexamethasone			
2. Prednisone			
3. Folinic Acid			
A. Antiemetics			
1. Ondansetron			
2. Metoclopramide			
B. Emergency Medicines (when necessary)			
1. Epinephrine			
C. Pain Medications			
1. Tramadol			
2. Morphine			
3. Others (specify)			
D. Sedatives (prior to procedure)			
1. Midazolam			
2. Nalbuphine			
3. Propofol			
4. Atropine			
5. Ketamine			

Annex "C-1" - ALL

Republic of the Philippines
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DATE: _____
NAME OF HOSPITAL _____
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PhilHealth ID Number _____

Mandatory and Other Services	**Status (place a √ if done or NA)**	**Dates**	**Conforme**
E. Laboratory and Diagnostic Procedures			
1. Bone Marrow Examination			
2. Immunophenotyping			
3. CSF analysis			
4. Cytospin			
5. Complete Blood Count			
6. PT/PTT			
7. BUN			
8. Creatinine			
9. ALT			
10. Bilirubin			
11. Uric acid			
12. Serum electrolytes			
13. Serum phosphorus			
14. Urinalysis			
15. Chest X-ray			
16. 2-D echocardiography			
17. Abdominal ultrasound			
18. Blood culture and sensitivity (as indicated)			
19. Urine culture and sensitivity (as indicated)			
20. Other culture and sensitivity analyses (as indicated)			
F. Blood Support			
1. Crossmatching			
2. Screening			
3. Processing			
G. Antimicrobials/antifungals depending on the sensitivity pattern of the particular contracted hospital which includes the following (if indicated):			
1. Meropenem			
2. Vancomycin			
3. Ceftazidime			
4. Ciprofloxacin			
5. Cefepime			
6. Piperacillin			
7. Tazobactam			
8. Fluconazole			
9. amphotericin			

Annex "C" Breast CA

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NAME OF HOSPITAL _____
NAME OF PATIENT _____
PhilHealth ID Number _____

CHECKLIST FOR MANDATORY AND OTHER SERVICES

BREAST CANCER: 1ST TRANCHE (SURGERY)

Mandatory and Other Services	Status (place a √ if done or NA)	Dates	Conforme
A.CP Clearance			
B.Technique			
C.Laboratory:			
1. CBC			
2. Creatinine			
1. FBS			
2. Calcium			
3. AST/ALT			
4. ECG			
5. Alkaline Phosphatase			
6. Chest X-ray			
7. Abdominal Ultrasound			
8. ER/PR Assay			
9. HER2/ neu expression			
10. Histopath/Cytology			
11. Liver Ultrasound			
12. Bone Scan (if patient has symptoms related to bone or elevated alkaline)			
13. CT Scan of whole abdomen (if abdominal ultrasound is inconclusive but there are symptoms referable to the abdominal organs)			
14. Blood Support (cross matching, screening, processing)			
D.Complete list of drugs given (e.g. antibiotics, pain relievers, etc. if indicated):			
1.			
2.			
3.			

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CHECKLIST FOR MANDATORY AND OTHER SERVICES

BREAST CANCER: 2nd TRANCHE (CHEMOTHERAPY)

Mandatory and Other Services	Status (place a √ if done or NA)	Dates	Conforme
A. Complete List of Drugs Given:			
1. Chemotherapy drugs			
a. For favorable risk profile			
1) Doxorubicin			
2) Cyclophosphamide			
b. For unfavorable risk profile			
1) Doxorubicin			
2) Cyclophosphamide			
3) Docetaxel or			
Paclitaxel			
2. Hormonotherapy drugs – for ER(+)/PR(+)/(-): if indicated			
a. Tamoxifen or			
b. Aromatase Inhibitor Letrozole			
3. Antiemetic drugs			
a. Ondansetron			
b. Metoclopramide			
4. Fluorouracil (if indicated)			
5. Methotrexate (if indicated)			
6. Granulocyte stimulating factor (if indicated)			
7. Antibiotics (if indicated)			
a.			
b.			
c.			
B. Radiation therapy (if indicated)			

Annex "C"KT

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PHILIPPINE HEALTH INSURANCE CORPORATION
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DATE: _____
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NAME OF PATIENT _____
PhilHealth ID Number _____

CHECKLIST FOR MANDATORY AND OTHER SERVICES
END STAGE RENAL DISEASE ELIGIBLE FOR KIDNEY TRANSPLANT (LOW RISK)

Mandatory and Other Services	Status (place a √ if done or NA)	Dates	Conforme
A. CP-clearance for donor (if indicated) and recipient			
B. Pre-transplant evaluation/labs (Phases1, 2, 3 and 4) for donor and recipient candidates			
C. Transplantation surgery with living or deceased donor			
D. Hemodialysis or peritoneal dialysis during admission for transplantation, if indicated			
E. Immunosuppressant induction therapy, unless identical twin or full HLA-antigen match			
F. Immunologic risk- At least 1 HLA-DR match between donor and recipient. primary kidney transplant, single organ transplant, PRA class 1 & 2 negative or PRA<20%; no donor specific antibody			
IMMUNOSUPPRESSION OPTIONS (CHOOSE 1, 2 OR 3 ONLY):			
1. Calceineurin inhibitor + mycophenolate + prednisone with or without induction a. Cyclosporine + mycophenolate motetil or mycophenolate sodium + prednisone OR b. Tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone			
2. Calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction a. Low-dose Cyclosporine + Sirolimus + prednisone OR b.Low-dose Cyclosporine + Everolimus + prednisone			
3. Calcineurin inhibitor Cyclosporine + azathioprine + prednisone with or without induction			
INDUCTION THERAPIES (CHOOSE 1 or 2 ONLY)			
1. Interleukin-2-receptor antibody (Basiliximab) 20 mg IV for 2 doses			
2. Lymphocyte depleting agents a. Alemtuzumab 30mg IV single dose OR b. Rabbit anti-thymocyte globulin 1.0-1.5mg per kg per day for 3 doses			
ANTI-REJECTION THERAPY, IF INDICATED 1.Methylprednisolone 500mg IV per day for 3 days			
Post-transplant laboratory monitoring of donor for one year, and for one month for recipient			
OTHER SERVICES			
a.)Graft renal biopsy, if indicated			
The following tests, if indicated: b.)Chest CT-scan c.) Dipyridamole sestamibi nuclear scam or dobutamine stress echocardiogram d.)Endoscopy e.)Colonoscopy f.)Pulmonary function test			

END STAGE RENAL DISEASE ELIGIBLE FOR KIDNEY TRANSPLANT (LOW RISK)

Mandatory and Other Services	Status (place a √ if done or NA)	Dates	Conforme
1. Laboratory Monitoring for RECIPIENT			
TIME AFTER HOSPITAL DISCHARGE FOR TRANSPLANTATION			
a.) 1 WEEK			
Complete blood count, creatinine, fasting blood sugar, potassium, therapeutic drug monitoring (one drug only)			
b.) 2 WEEKS			
Complete blood count, creatinine, fasting blood sugar, SGPT, lipid profile, therapeutic drug monitoring (one drug only)			
c.) 3 WEEKS			
Complete blood count, creatinine, fasting blood sugar			
d.) 4 WEEKS			
Complete blood count, creatinine, fasting blood sugar			
2. Laboratory Monitoring for DONOR			
TIME AFTER HOSPITAL DISCHARGE FOR NEPHRECTOMY			
a.) 2 OR 4 WEEKS			
Complete blood count, creatinine, urinalysis			
b.) 3 MONTHS			
creatinine, urinalysis			
c.) 6 MONTHS			
creatinine, urinalysis			
d.)12 MONTHS			
creatinine, urinalysis			

* urine protein/creatinine ratio can be done once within the year, if indicated

Laboratory Monitoring for RECIPIENT

TIME AFTER HOSPITAL DISCHARGE FOR TRANSPLANTATION	LAB TEST
1 WEEK	Complete blood count, creatinine, fasting blood sugar, potassium, therapeutic drug monitoring (one drug only)
2 WEEKS	Complete blood count, creatinine, fasting blood sugar, SGPT, lipid profile, therapeutic drug monitoring (one drug only)
3 WEEKS	Complete blood count, creatinine, fasting blood sugar
4 WEEKS	Complete blood count, creatinine, fasting blood sugar

Laboratory Monitoring for DONOR

TIME AFTER HOSPITAL DISCHARGE FOR NEPHRECTOMY	LAB TEST
2 OR 4 WEEKS	Complete blood count, creatinine, urinalysis
3 MONTHS	creatinine, urinalysis
6 MONTHS	creatinine, urinalysis
12 MONTHS	creatinine, urinalysis

* urine protein/creatinine ratio can be done once within the year, if indicated

Annex "C" Prostate

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Healthline 441-7442 *www.philhealth.gov.ph*

DATE: _____
NAME OF HOSPITAL _____
NAME OF PATIENT _____
PhilHealth ID Number _____

CHECKLIST FOR MANDATORY AND OTHER SERVICES

PROSTATE CANCER

Mandatory Service	Status (place a √ if done or NA)	Dates	Conforme
A. CP Clearance			
B. Operation Technique			
1. Radical prostatectomy OR			
2. Laparoscopic prostatectomy			
C. Chest X-ray			
D. Laboratory:			
1. Creatinine			
2. FBS			
3. CBC			
4. Electrolytes			
5. ECG			
E. Abdominal Ultrasound (as needed)			

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly healthcare provider or you may contact PhilHealth call center at 4417444. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:
   - ☐ Acute Lymphoblastic Leukemia
   - ☐ Breast Cancer
   - ☐ Prostate Cancer
   - ☐ Kidney Transplant

2. Patient's age is:
   - ☐ 19 years old & below
   - ☐ between 20 to 35
   - ☐ between 36 to 45
   - ☐ between 46 to 55
   - ☐ between 56 to 65
   - ☐ above 65 years old

3. Sex of respondent
   - ☐ male
   - ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the hospital in terms of availability of medicines needed for the treatment of the condition?
   - ☐ inadequate
   - ☐ adequate
   - ☐ don't know

5. How would you rate the patient’s or family’s involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
   - excellent
   - satisfactory
   - unsatisfactory
   - don’t know

6. In general, how would you rate the healthcare professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
   - excellent
   - satisfactory
   - unsatisfactory
   - don’t know

7. In your opinion, by how much has your hospital expenses been lessened by availing of the Z benefit package?
   - less than half
   - by half
   - more than half
   - don’t know

8. Overall patient satisfaction (PS mark) is:
   - excellent
   - satisfactory
   - unsatisfactory
   - don’t know

9. If you have other comments, please share them below:
   _____
   _____
   _____

Thank you. Your feedback is important to us!

TRANSPLANT OPERATION

<table>
<tr><th>TRANSPLANTATION SURGERY
WITH LIVING DONOR
MANDATORY SERVICES</th><th>OTHER SERVICES*
IF INDICATED</th></tr>
<tr><td rowspan="3">Hemodialysis or CAPD/CCPD/NIPD pre-transplant

Transplantation Surgery
Post-operative pain control
Post-operative graft duplex ultrasound
Chest xray, if indicated

Graft biopsy, if indicated
Indication: Serum creatinine fails to decrease progressively or rises, assuming target levels of immunosuppression are reached.</td><td>* some tests in mandatory services may be repeated if initially abnormal and an intervention ordered necessitating a repeat of the test after a certain period, to determine if acceptable</td></tr>
<tr><td>PROCEDURES</td></tr>
<tr><td>Graft nuclear scan
Indications:
1. More than 2 renal arteries or veins anastomosed.
2. Graft dysfunction</td></tr>
<tr><td rowspan="2">Induction immunosuppression with Basiliximab or rATG (1 mg/kg/day)

Intravenous methylprednisolone 500mg x 3 days for clinical or biopsy-proven acute rejection</td><td>Dopamine, dobutamine, levophed administration if necessary</td></tr>
<tr><td>Plasmapheresis, intravenous immunoglobulin, rituximab or antithymocyte globulin or alemtuzumab for antibody-mediated acute rejection</td></tr>
<tr><td>Maintenance immunosuppression</td><td>Hemodialysis for delayed graft function</td></tr>
<tr><td>Post-surgical antibiotic prophylaxis (antibiotics according to transplant facility practice)</td><td></td></tr>
<tr><td>Acid pump inhibitor

Transplant infection antibiotic prophylaxis (isoniazid, co-trimoxazole forte)

Transplant infection antiviral prophylaxis valacyclovir for herpes prophylaxis

Transplant infection fungal prophylaxis prophylaxis (oral mycostatin)</td><td>Insulin administration
Intravenous calcium, potassium correction
H2 blocker, other antacids</td></tr>
</table>

Blood glucose monitoring, if indicated Continuation of pre-transplant medications including anti-hypertensives, anti-ischemics and other cardiac medications, anti-thrombotics. Calcium carbonate with vitamin D	
LABORATORY EXAMINATIONS ONCE ADMITTED FOR TRANSPLANT	
Must be within the last 7 days pre KT: CBC, creatinine, potassium, PT, PTT, BT;	
6 hours immediately post-op: CBC, creatinine, sodium, potassium	
Day 1 post KT: CBC, creatinine, SGPT, calcium, sodium, potassium,	
Days 2-5 post KT: CBC, creatinine	Serum sodium, potassium, calcium if correction is administered.
Days: therapeutic drug monitoring (see protocols), 2 DETERMINATIONS POST-TRANSPLANT	ECG, 2D-echocardiogram
Urinalysis,	CD3, CD4 for patients given anti-thymocyte globulin
	Sputum GS/CS, blood C/S
	Arterial blood gas
	Cardiac enzymes, liver enzymes

TRANSPLANTATION SURGERY WITH DECEASED DONOR MANDATORY SERVICES	**OTHER SERVICES***
All the above are the same except for the following:	*some tests in mandatory services may be repeated if initially abnormal and an intervention ordered necessitating a repeat of the test after a certain period, to determine if acceptable
Hemodialysis or CAPD/CCPD/NIPD post-transplant may be needed in case of delayed graft function	
Cardiology evaluation may be needed if the recipient had a recent cardiac event.	
Pulmonary evaluation may be needed if the recipient has an abnormal cheat xray.	

DONOR NEPHRECTOMY

DONOR SURGERY MANDATORY SERVICES	OTHER SERVICES*
Laparoscopic donor nephrectomy, Unless with contraindications Post-operative pain control Post-operative antibiotic prophylaxis Iron supplementation	*some tests in mandatory services may be repeated if initially abnormal and an intervention ordered necessitating a repeat of the test after a certain period, to determine if acceptable

POST-TRANSPLANT RECIPIENT MONITORING

POST TRANSPLANT MONITORING OF RECIPIENT MANDATORY SERVICES	OTHER SERVICES
FIRST POST-TRANSPLANT YEAR FOLLOW-UP SCHEDULE * May be more frequent if any complication occurs (example. acute rejection, rise in creatinine, abnormal lab results)	
WEEKLY FOLLOW-UP x 4 WEEKS (WEEK 1-4)	
Weekly CBC, FBS, creatinine	
Once in the first month: Potassium, SGPT, lipid profile, urinalysis	
Week 1 and 2: Therapeutic drug monitoring (TDM)	TDM may be done more frequently if doses of immunosuppression are altered or drugs that affect blood levels of immunosuppression are used.

POST-NEPHRECTOMY DONOR MONITORING

POST TRANSPLANT MONITORING OF DONOR MANDATORY SERVICES	OTHER SERVICES
FIRST POST-NEPHRECTOMY YEAR FOLLOW-UP SCHEDULE * May be more frequent if any complication occurs	
2 WEEKS POST-OP, 1-, 3-, 6-MONTHS, ANNUAL POST-OP FOLLOW-UP	
Week 1: Follow-up with surgeon	
Month 1: CBC, creatinine, urinalysis	
Month 3, 6, 12 and annual: creatinine, urinalysis	Urine protein/creatinine ratio if proteinuria is positive on urinalysis.