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
STANDARD RISK ELECTIVE CORONARY ARTERY BYPASS GRAFT SURGERY

(Place a ✓or NA)

QUALIFICATIONS	Yes	Attested by Attending MD	Conforme by Patient
1. Age 19 – 70 years	[ ]		
2. Stable Coronary Artery Disease requiring ELECTIVE ISOLATED Coronary Artery Bypass Graft Surgery (CABG) with indication based on coronary anatomy, symptom severity, LV function, and/or viability tests; non-invasive testing completed and discussed with patient	[ ]		
3. Check current medical status: a. NOT in severe decompensated heart failure (NYFC IV) b. NOT with severe angina (CCS Class III) c. NO other cardiac/vascular procedures/interventions planned to be done with CABG during this admission	 [ ] [ ] [ ]		
4. Check Past History: a. NO previous cardiac surgery such as CABG, valve surgery, etc. b. NO previous transcutaneous cardiac intervention such as coronary angioplasty or stenting	 [ ] [ ]		
5. ONLINE EUROSCORE II and/or STS scoring predictive of low mortality risk (< 5%)	[ ]		

DIAGNOSTICS	Yes	Date done	Attested by Attending MD	Conforme by Patient
Check : 1. Coronary Angiography: coronary anatomy amenable for CABG and consistent with Class I and IIa indications for CABG and discussed with patient 2. Current status of myocardial viability consistent with benefit from CABG and discussed with patient	 [ ] [ ]	BOTH at least within 1 year from date of application		

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PRE-AUTHORIZATION REQUEST
STANDARD RISK ELECTIVE CORONARY ARTERY BYPASS GRAFT SURGERY

DATE OF REQUEST___________________________

This is to request approval for provision of services under the Z benefit package for

____________________________________ in ____________________________________
(COMPLETE 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 (tick appropriate box):

☐ **NBB**
☐ **FIXED CO-PAY** Indicate amount (Php) ____________

Requested by:

____
Printed Name & Signature
Attending Cardiologist

Noted by:

____
Printed Name & Signature
Executive Director/Chief of Hospital

____
Printed Name & Signature
Attending Cardiovascular Surgeon

(For Philhealth Use Only)

☐ **APPROVED**
☐ **DISAPPROVED**

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

DATE: ___________________________