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
TETRALOGY OF FALLOT SURGERY

(Place a ✓or NA)

QUALIFICATIONS	Yes	Attested by Attending Pediatric Cardiologist
1. Age at least 1 year old – 10 years + 364 days	☐	
2. Check Past History: a. No previous cardiac surgery or intervention such as BTS (Blalock Taussig Shunt) b. No PDA Stenting or c. No residual VSD from previous Open heart Surgery For Total Correction	☐	
3. Check Physical Examination: No hepatomegaly or No edema lower extremities	☐	
4. No Congenital Chromosomal Abnormalities or other congenital defects	☐	

DIAGNOSTICS	Yes	Date done	Attested by Attending Pediatric Cardiologist
Check 2D Echocardiogram*: a. Verify Ventricular Septal Defect and Pulmonic Stenosis, moderate to severe b. No other associated CHD's : absent pulmonic valve; Atrioventricular Septal Defect (AVSD) c. Adequate pulmonary artery sizes or Acceptable Pulmonary valve Annulus d. No collaterals or MAPCA's	☐ ☐ ☐ ☐	At least within 1 year from date of application _____	

*Attach OFFICIAL 2D ECHO RESULTS

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

PRE-AUTHORIZATION REQUEST
TETRALOGY OF FALLOT 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.

Requested by:

_____
Printed Name & Signature
Attending Pediatric Cardiologist/ OPD Consultant

SOCIAL SERVICE ASSESSMENT

The patient belongs to the following category:
☐ NBB ☐ FIXED CO-PAY (Indicate Amount) Php _____

Assessed by : _____

CONFIRMED BY

_____
Printed Name & Signature
(Check Appropriate Box)
☐ Chair, Department of Pediatric Cardiology
☐ Chief, Division of Pediatric CV Surgery

NOTED BY:

_____
Executive Director / Chief of Hospital

(For Philhealth Use Only)

☐ APPROVED
☐ DISAPPROVED

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

DATE: _____