



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
VENTRICULAR SEPTAL DEFECT (VSD) CLOSURE**

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:

Printed Name & Signature

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: _____