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. 0002, s-2013

TO : **ALL PHILHEALTH MEMBERS, ACCREDITED AND CONTRACTED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **Z BENEFIT PACKAGE RATES FOR CORONARY ARTERY BYPASS GRAFT SURGERY, SURGERY FOR TETRALOGY OF FALLOT, SURGERY FOR VENTRICULAR SEPTAL DEFECT AND CERVICAL CANCER**

I. RATIONALE

Pursuant to Philhealth Board Resolution No. 1629 s. 2012, and Philhealth Circular No. 29, s. 2012, "Governing Policies on Philhealth Benefit Package for Case Type Z", the following are the services and rates for coronary artery bypass graft surgery (CABG), surgery for Tetralogy of Fallot (TOF), surgery for ventricular septal defect (VSD), and cervical cancer.

The illnesses and their risk classification included are as follows:

1. Standard Risk Elective Surgery for: Coronary Artery Bypass Graft (CABG), Total Correction of Tetralogy of Fallot (TOF), and Surgery for Ventricular Septal Defect (VSD);
2. Cervical Cancer Stage I to IIIB;

These conditions were chosen based on current evidence that quality treatment significantly increases survival rates and quality of life. Moreover, valid information for these conditions is readily available.

II. RULES FOR IDENTIFIED CASE TYPE Z

A. Only newly diagnosed cases of cervical cancer shall be covered under the benefit package. For coronary artery bypass graft surgery, total correction of TOF and closure of VSD, only those cases that strictly fulfill the selections criteria shall be covered;

B. Beginning January 1, 2013, all members availing of the Z Benefit shall be required a 3-year lock-in membership prior to availment of the benefit. The lock-in membership does not apply to lifetime members and sponsored program members;

C. Pre-authorization from Philhealth based on the approved selections criteria per specific Z condition shall be required prior to availment of services. All requests for pre-authorization shall be completely accomplished by the

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contracted hospital and submitted to the Head of the Regional Benefits Administration Section for approval or disapproval;

D. The diagnosis during pre-authorization shall be the basis for reimbursement;

E. No balance billing (NBB) policy shall be applied for eligible sponsored program members and their qualified dependents. Negotiated fixed co-pay shall be applied for eligible non-sponsored members and their qualified dependents. In no instance shall the fixed co-pay exceed the package rate;

F. The professional fees for surgery of CABG, TOF and VSD shall be 20% of the package rate; the professional fees for cervical cancer is 15% of the package rate;

G. Patients enrolled in the Z benefit will be deducted a maximum of five (5) days from the 45 days annual benefit limit regardless of the actual length of stay of the patient in the hospital. Such deductions shall be made on the current year and no deductions shall be made in the succeeding year. In cases where the remaining annual benefit limit is less than five (5) days, the member shall remain eligible to avail of the Z Benefit, provided that premiums are updated;

H. Any complication/s arising during the hospital confinement for the particular Z condition shall be part of the package;

I. Hospital confinements due to other causes as determined by the primary condition shall be paid separately;

J. All rates are inclusive of government taxes;

K. Rules on pooling of professional fees for government facilities shall apply;

L. In cases when the patient expires anytime during the course of treatment or the patient is lost to follow up, the payment schedule for the specific treatment phase shall still be released as long as the patient has received the scheduled treatment. The remaining tranche shall not be paid.

M. All mandatory and other services of the specific Z conditions shall be given according to the approved clinical pathways, treatment protocols, clinical guidelines and other standards of care.

III. CASE TYPE Z

A. Elective Surgery for Standard Risk Coronary Artery Bypass Graft

1. The package code is **Z005** which includes the following ICD-10 and RVS codes:

ICD 10	MANAGEMENT/PROCEDURES	RVS CODES
I20 I25	Coronary Artery Bypass Graft Surgery	33510-33516 33517-33523 33533-33536 33572

2. The package rate shall be P550, 000 for the entire course of treatment.
3. Selections criteria for CABG:
   a. Signed Member Empowerment (ME) Form
   b. Age 19-70 years

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c. 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

d. Current Medical Status
   i. Not in severe decompensated heart failure (NYFC IV)
   ii. Not with severe angina (CCS Class III)
   iii. No other cardiac/vascular procedures/interventions planned to be done with CABG during the admission

e. Past History:
   i. No previous cardiac surgery such as CABG, valve surgery, etc.
   ii. No previous transcutaneous cardiac intervention such as coronary angioplasty or stenting

f. ONLINE EUROSCORE II and/or STS scoring predictive of low mortality risk (< 5%)

4. The approved clinical pathway for CABG shall reflect the mandatory and other services as indicated in the table below.

MANDATORY SERVICES	OTHER SERVICES
1. Pre-op lab tests: CBC, platelet count, blood typing, Na, K, Mg, Calcium, FBS, BUN, creatinine, chest x-ray (PA/lateral), 12-lead ECG, room air ABG 2. Preoperative antibiotic prophylaxis (ex. vancomycin and amikacin) 3. Medications, as indicated, such as beta blocker, statin , ACE inhibitor or ARB, ASA 4. Blood support – screening and blood products, as needed 5. Pre-operative evaluation/CP clearance 6. Open Heart Surgery under general anesthesia 7. Immediate postoperative care at surgical ICU 8. Continuing postoperative care at regular room 9. Cardiac Rehabilitation	1. Additional laboratory tests as needed, intra-operatively or postoperatively e.g. ankle-brachial index, carotid duplex scan; postoperative CBC, platelet count, APTT, PTPA-INR, FBS, Na, K, Mg, Calcium, BUN, creatinine, TPAG, urinalysis, chest x-ray (portable/AP/lateral), 12-lead ECG, ABG, 2DED, TEE, as indicated 2. Postoperative antibiotics if indicated (IV and oral) 3. Treatments, as indicated, such as: a. Incentive spirometry b. VTE Prophylaxis with compression stockings/ intermittent pneumatic compression/ intravenous/subcutaneous heparin, LMWH, fondaparinux c. Nebulization with medications such as beta agonist + steroid or salbutamol/pulmonary physiotherapy d. Blood glucose monitoring e. Wound dressings/wound care 4. Other medications, as indicated, such as: clopidogrel, digoxin, furosemide IV or oral, amiodarone, vasopressors (dopamine, levophed, epinephrine infusion drip), inotropic drugs (dobutamine infusion drip),vasodilator (NTG or Isoket or Nicardipine), insulin regimen, oral hypoglycemic drugs, proton pump inhibitor/antacid, pain relievers/analgesics, sedatives/anxiolytics, magnesium chloride, calcium gluconate, potassium chloride, lactulose/stool softeners 5. Pulmonary care, as indicated, such as ventilator support; nebulization, with beta 2 agonist/ combination with steroid 6. Other specialty services as needed, such as pulmonology, nephrology, neurology, infectious disease, etc.

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5. The payment for this package shall be **Five Hundred Fifty Thousand pesos (P550,000)** for the complete course of care which shall be given in two (2) tranches as follows:

MODE OF PAYMENT	AMOUNT	FILING SCHEDULE
1st tranche	P500,000	Within 60 days after discharge from surgery
2nd tranche	P50,000	Within 60 days after the first follow-up, one week post-discharge (to check the vital signs and hemodynamic status, operative site wound care, continuation of cardiac rehabilitation OPD phase of program)

B. Surgery for Total Correction of Tetralogy of Fallot

1. The package code is **Z006** which includes the following ICD-10 and RVS codes:

ICD 10	MANAGEMENT/PROCEDURES	CODES
Q21.3	Total Correction of Tetralogy of Fallot	33692, 33694, 33697

2. The package rate shall be P320, 000 for the entire course of treatment.
3. Selections criteria for surgery for TOF:
   a. Signed Member Empowerment (ME) Form
   b. Age: 1 to 10 years + 364 days
   c. 2D Echocardiogram :
      i. Pulmonary artery size
         - McGoon's index (Aorta/Pa ratio) $\geq$ 1.5
         - Z score Pulmonary Valve Annulus : Acceptable if z score /BSA : $\geq$ 3 or better
         - Z score peripheral PA's : Acceptable if $\geq$ 2 or better
      ii. Absence of major aortopulmonary collateral arteries (MAPCAs)
   d. If cardiac catheterization / hemodynamic study available: PA size: adequate by Z score standards/ BSA
   e. No previous cardiac surgery (Blalock Taussig Shunt)
   f. Functional Class I-II
   g. No co-morbid factors, such as any of the ff:
      iii. Preoperative seizures
      iv. Brain abscess
      v. Stroke events
      vi. Bleeding disorders
      vii. Infective endocarditis
      viii. Other congenital anomalies

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4. The approved clinical pathways for TOF shall reflect the mandatory and other services as indicated in the table below.

MANDATORY SERVICES	OTHER SERVICES
1. Pre-op labs: CBC platelet count, Na K Ca Mg, PT PTT, creatinine 2. Pre-operative clearance/CP clearance 3. Open heart surgery for total correction of TOF under general anesthesia 4. Post-op labs: PT, PTT 5. Pulmo labs: ABG pre-op, ABG lactate electrolytes, capnograph 6. Radiology: chest x-ray 7. Non-invasive labs, as indicated: TOTEE, post-op Echo-CFDS, 15-lead ECG 8. Other labs, as indicated: drug assay 9. Pre-op meds: antibiotic prophylaxis (ex. vancomycin, amikacin), methylprednisolone 10. Other meds as indicated: dopamine, dobutamine, milrinone, furosemide IV, calcium gluconate, digoxin (oral), furosemide oral, ibuprofen, captopril 11. Blood support--screening & blood products 12. Pedia Care Rehabilitation (4 sessions)	1. Postoperative antibiotics as indicated (intravenous and oral) 2. Other meds, as indicated, such as oral 2nd gen cephalosporins and oral ciprofloxacin, if necessary 3. Pulmonary care, when needed, such as ventilator support, nebulizations, etc. 4. Other specialty services as needed, such as pediatric infectious disease, etc.

5. The payment for this package shall be **Three Hundred and Twenty Thousand pesos (Php 320, 000)** for the complete course of care which shall be given in two (2) tranches as follows:

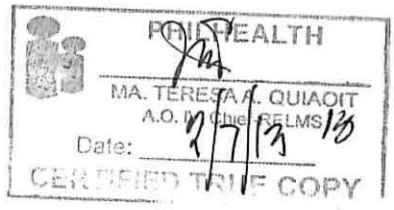
MODE OF PAYMENT	AMOUNT	FILING SCHEDULE
1st tranche	P270, 000	Within 60 days after discharge from surgery
2nd tranche	P50, 000	Within 60 days after completion of Rehabilitation Exercise Sessions (3rd–4th session in the first week post-op)

C. **Surgery for Closure of Ventricular Septal Defect**

1. The package code is **Z007** which includes the following ICD-10 and RVS codes:

ICD 10	MANAGEMENT/PROCEDURES	RVS CODES
Q21	Closure of Ventricular Septal Defect with or without patch	33681

2. The package rate shall be P250, 000 for the entire course of treatment.
3. Selections criteria for surgery for VSD:
   a. Signed Member Empowerment (ME) Form
   b. Age: 1 to 5 years + 364 days
   c. 2D-echocardiography
      i. Isolated VSD perimembranous, subaortic or subpulmonic
      ii. No combined shunts such as atrial septal defect or patent ductus arteriosus or atrioventricular septal defect



iii. No other associated CHD's : such as coarctation of the aorta, or moderate to severe aortic insufficiency, or moderate to severe pulmonic stenosis
iv. Pulmonary artery pressure: < 50 mmHg or at least 2/3 systolic blood pressure
v. QP QS: > 1.5:1

d. No previous cardiac surgery (PA Banding)
e. Functional Class I-II
f. No co-morbid factors, such as any of the ff:
i. Preoperative seizures
ii. Brain abscess
iii. Stroke events
iv. Bleeding disorders
v. Infective endocarditis
g. No chromosomal abnormalities and other associated congenital defects

4. The approved clinical pathways for VSD shall reflect the mandatory and other services as indicated in the table below.

MANDATORY SERVICES	OTHER SERVICES
1. Pre-op Labs: CBC Platelet count, Na K Ca Mg, PT PTT, creatinine 2. Pre-operative evaluation/CP clearance 3. Surgery: VSD patch closure under general anesthesia 4. Post-op labs: PT, PTT 5. Pulmo labs: ABG pre-op, ABG lactate electrolytes, capnograph 6. Radiology: chest x-ray 7. Non-invasive Labs: TOTEE 8. Pre-op meds: antibiotic prophylaxis (ex. vancomycin, amikacin), methylprednisolone 9. Other meds, as indicated: dopamine, dobutamine, milrinone, furosemide IV, calcium gluconate, digoxin (oral), furosemide oral, ibuprofen, captopril 10. Blood support--screening and blood products 11. Pedia Care Rehabilitation (4 sessions)	1. Postoperative antibiotics as indicated (intravenous and oral) 2. Other meds, as indicated, such as oral 2nd gen cephalosporins and ciprofloxacin, if necessary 3. Pulmonary care, when needed, such as ventilator support, nebulizations, etc. 4. Other specialty services as needed, such as pediatric infectious disease, etc.

5. The payment for this package shall be **Two Hundred Fifty Thousand pesos (Php 250, 000)** for the complete course of care which shall be given in two (2) tranches as follows:

MODE OF PAYMENT	AMOUNT	FILING SCHEDULE
1st tranche	P200, 000	Within 60 days after discharge from surgery
2nd tranche	P50, 000	Within 60 days after completion of Rehabilitation Exercise Sessions (3rd-4th session in the first week post-op)

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C. **Cervical Cancer Chemoradiation with Cobalt & Brachytherapy (Low Dose) or Primary Surgery for Stage IA1, IA2-IIA1**

1. The package code is **Z008** which includes the following ICD-10 and RVS codes:

ICD 10	MANAGEMENT/PROCEDURES	RVS CODES
C53	**Histopathology** Cervical biopsy Cone biopsy LEEP	57500 57520 57522
	Chemotherapy	96408
	Radiotherapy Pelvic Cobalt	77401
	Brachytherapy (low dose) surface, interstitial or intracavitary	77761
	For Stage IA1 only: Total Extrafascial Hysterectomy with or without bilateral salpingoophorectomy	58150
	For stage IA2-IIA1: Radical hysterectomy with bilateral pelvic lymphadenectomy and paraaortic lymph node sampling with or without bilateral salpingoophorectomy	58210

2. The package rate shall be P120, 000 for the entire course of treatment.
3. Selections criteria
   a. Signed ME Form
   b. No previous chemotherapy
   c. No previous radiotherapy
   d. No uncontrolled co-morbid conditions
   e. Treatment plan from gynecologic oncologist
4. The approved clinical pathways for Cervical Cancer Primary Surgery shall reflect the mandatory and other services as indicated in the table below.

MANDATORY SERVICES	OTHER SERVICES
1. Pre-op/pre-procedure labs, as indicated: CBC, platelet count, blood typing, FBS, creatinine, SGOT, SGPT, serum electrolytes, Mg, PT/PTT, AST/ALT, urinalysis, ECG, chest x-ray 2. Imaging studies, as indicated: transvaginal ultrasound, whole abdominal CT scan or MRI 3. Pre-op/pre-procedure clearance 4. Pre-op meds: antibiotic prophylaxis, such as cefoxitin, cefuroxime 5. Surgery (for Stage IA1 and Stage IA2-IIA1) under spinal epidural anesthesia 6. Chemotherapy (ex. cisplatin, carboplatin) 7. Radiotherapy (pelvic cobalt) 8. Brachytherapy (low dose rate) 9. Post-op/post-procedure labs : CBC with platelet 10. Blood Support (ex. cross matching, screening, processing)	1. Cystoscopy or proctosigmoidoscopy, if indicated 2. Other meds as indicated: tranexamic acid, calcium gluconate, analgesics 3. Postoperative antibiotics as indicated (intravenous and oral) 4. Support Medications—when indicated and needed, such as anti-emetics (ex. ramosetron, granisetron, metoclopramide), G-CSF, hematinics, etc.

5. The payment for this package shall be **One Hundred Twenty Thousand pesos (Php 120, 000)** for the complete course of care which shall be given in two (2) tranches as follows:

MODE OF PAYMENT	AMOUNT	FILING SCHEDULE
1ST tranche	**P100, 000**	Within 60 days after discharge from surgery or from the last cycle of chemoradiation
2nd tranche	**P20, 000**	Within 60 days after the first follow-up without complications. (Pelvic exam done)

D. **Cervical Cancer Chemoradiation with Linear Accelerator & Brachytherapy (High Dose)**

1. The package code is **Z009** which includes the following ICD-10 and RVS codes:

ICD 10	MANAGEMENT/PROCEDURES	RVS CODES
C53	**Histopathology**	
	Cervical biopsy	57500
	Cone biopsy	57520
	LEEP	57522
	Chemotherapy	96408
	Radiotherapy	
	Linear Accelerator	77401
	Brachytherapy (high dose) surface, interstitial or intracavitary	77761

2. The package rate shall be P175, 000 for the entire course of treatment.
3. Selections criteria
   a. Signed ME Form
   b. No previous chemotherapy
   c. No previous radiotherapy
   d. No uncontrolled co-morbid conditions
   e. Treatment plan from gynecologic oncologist
4. The approved clinical pathways for Cervical Cancer Chemoradiation shall reflect the mandatory and other services as indicated in the table below.

MANDATORY SERVICES	OTHER SERVICES
1. Pre-procedure labs, as indicated: CBC, platelet count, blood typing, FBS, creatinine, SGOT, SGPT, serum electrolytes, Mg, PT/PTT, AST/ALT, urinalysis, ECG, chest x-ray 2. Imaging studies: transvaginal ultrasound, whole abdominal CT scan 3. Pre-procedure clearance 4. Pre-procedure meds, as needed: antibiotic prophylaxis such as cefoxitin, cefuroxime 5. Chemotherapy (ex. cisplatin, carboplatin) 6. Radiotherapy (linear accelerator) 7. Brachytherapy (high dose rate) 8. Post-procedure labs : CBC with platelet 9. Blood Support (ex. cross matching, screening, processing)	1. Cystoscopy or proctosigmoidoscopy, if indicated 2. Other meds as indicated: tranexamic acid, calcium gluconate, analgesics 3. Post-procedure antibiotics as indicated (intravenous and oral) 4. Support Medications—when indicated and needed, such as anti-emetics (ex. ramosetron, granisetron, metoclopramide), G-CSF, hematinics, etc.

5. The payment for this package shall be **One Hundred Seventy Five Thousand pesos (Php 175, 000)** for the complete course of care which shall be given in two (2) tranches as follows:

MODE OF PAYMENT	AMOUNT	FILING SCHEDULE
1st tranche	P125, 000	Within 60 days from the last cycle of chemoradiation
2nd tranche	P50, 000	Within 60 days after first follow-up without complications. (Pelvic exam done)

IV. OUTPATIENT LABORATORY AND DIAGNOSTICS

All pre-op/pre-procedure laboratory and diagnostic examinations necessary for surgical clearance or mandatory procedures with official receipts and which are done on an outpatient basis shall be reimbursed by the hospital to the patient once PhilHealth has paid the first tranche payments to the hospital.

V. CLAIMS FILING

All claims shall be filed by the contracted hospitals in behalf of the patient according to the ***Implementing Guidelines on the Z Benefit Package*** (PhilHealth Circular 48, s. 2012).

VI. EFFECTIVITY

This Circular shall take effect for all approved pre-authorizations starting February 13, 2013. This shall be published in any newspaper of general circulation and deposited thereafter with the Office of the National Administrative Register, University of the Philippines Law Center.

VII. ANNEXES

1. Pre-authorization checklist and request
    a. CABG
    b. TOF
    c. VSD
    d. Cervical Cancer
2. Checklist for Mandatory and Other Services
    a. CABG
    b. TOF
    c. VSD
    d. Cervical Cancer

Please be guided accordingly.

ENRIQUE T. ONA, MD
Secretary of Health
OIC – President and CEO
Date signed: 2-6-13

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MA. TERESA A. QUIAOIT
A.O IV, Chief, RELMS
Date: 2/7/13
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Healthline 441-7444 www.philhealth.gov.ph

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

_____
Printed Name & Signature
Attending Cardiovascular Surgeon

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: _____

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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 N.A)

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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Date _____ Date Admitted : _____

Name of Hospital _____ Date Discharged: _____

Name of Patient _____

PhilHealth ID Number _____

STANDARD RISK ELECTIVE CORONARY ARTERY BYPASS GRAFT SURGERY (CABG) CHECKLIST OF MANDATORY and OTHER SERVICES

MANDATORY SERVICES	Confirmed done / Date signed
I. Preoperative Laboratory tests such as : • CBC • Platelet count • Blood typing • Na • K • Mg • Calcium • FBS • BUN • Creatinine • Chest XRay (PA/lateral) • 12-LEAD ECG • Room air ABG • Protime-INR • Plasma thromboplastin time	_____ Name & Signature of Cardiologist
II. Medications • BetaBlocker • Statin • ACE inhibitor or ARB • ASA • Preoperative Antibiotic Prophylaxis	_____ Name & Signature of Cardiologist
III. Blood bank screening and blood products as indicated	_____ Authorized Blood Bank Staff

IV. Open Heart Surgery under General Anesthesia	_____ Cardiovascular Surgeon _____ Anesthesiologist
V. Immediate Postoperative Care at Surgical ICU	_____ Cardiologist
VI. Continuing Postoperative Care at Regular room	_____ Cardiologist
VII. Cardiac Rehabilitation	_____ Authorized Cardiac Rehab Staff

OTHER SERVICES	Confirmed done by Cardiologist /Date signed
1. Additional laboratory tests as needed e.g. CBC, Platelet count, APTT, PTPA INR, FBS, Na, K, Mg, Calcium, BUN, Creatinine, TPAG, ABG, Urinalysis	
2. Additional Chest x-ray (portable/AP/lateral), 12-lead ECG, 2DED, TEE, as indicated	
3. Ankle-brachial index, carotid duplex scan as indicated	
4. Postoperative antibiotics if indicated (IV and oral)	
5. Treatments as indicated a. Incentive spirometry b. VTE Prophylaxis with compression stockings/ intermittent pneumatic compression/ intravenous/subcutaneous heparin, LMWH, fondaparinux c. Nebulization with medications such as beta agonist + steroid or salbutamol/pulmonary physiotherapy d. Blood glucose monitoring	

e. Wound dressings/wound care	
6. Other medications, as indicated, such as: clopidogrel, digoxin, furosemide IV or oral, amiodarone, vasopressors (dopamine, levophed, epinephrine infusion drip), inotropic drugs (dobutamine infusion drip),vasodilator (NTG or Isoket or Nicardipine), insulin regimen, oral hypoglycemic drugs, proton pump inhibitor/antacid, pain relievers/analgesics, sedatives/anxiolytics, magnesium chloride, calcium gluconate, potassium chloride, lactulose/stool softeners	
7. Pulmonary care, as indicated, such as ventilator support; nebulization, with beta 2 agonist/ combination with steroid	
8. Other specialty services as needed, such as pulmonology, nephrology, neurology, infectious disease, etc.	

CONFORME BY PATIENT:

_____
Printed Name and Signature

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STANDARD RISK ELECTIVE
CORONARY ARTERY BYPASS GRAFT SURGERY (CABG)

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth:_____
_____
Date of Admission: _____
Date of Discharge: _____

TRANCHE I REQUIREMENTS CHECKLIST

I. First Tranche Payment	Please Check
1. Copy of Completely Accomplished ME FORM	
2. Completed Philhealth FORMS 1 AND 2	
3. Completed Z Satisfaction Questionnaire	
4. Copy of Approved Pre –Authorization Checklist & Request	
5. Completed Pre-claims Assessment of Services Checklist	
6. Accomplished Surgical Operative Report	
7. Accomplished Anaesthesia Report	
8. Discharge Summary Signed by Attending Physician	
DATE COMPLETED : DATE FILED :	

Attested by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Medical Center Chief

CONFORME BY PATIENT:

_____
Printed Name and Signature

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STANDARD RISK ELECTIVE
CORONARY ARTERY BYPASS GRAFT SURGERY (CABG)

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth: _____
_____
Date of Admission: _____
Date of Discharge: _____ :

TRANCHE 2 REQUIREMENTS CHECKLIST

II. Second Tranche Payment	Please check
1. Completed Cardiac Rehab Form	
2. Completed Certificate of OPD Follow-up consultation	
DATE COMPLETED : DATE FILED :	

Attested by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Medical Center Chief

CONFORME BY PATIENT

_____
Printed Name and Signature

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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: _____

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief-RELMS
Date: 2/7/13
CERTIFIED TRUE COPY

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 N.A)

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

2/7/13

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PHILIPPINE HEALTH INSURANCE CORPORATION

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Healthline 441-7444 www.philhealth.gov.ph

TETRALOGY OF FALLOT – ELECTIVE TOF REPAIR

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth:_____

_____

Date of Admission: _____
Date of Discharge: _____

TRANCHE I REQUIREMENTS CHECKLIST

I. First Tranche Payment	Please Check
1. Copy of Completed ME FORM	
2. Copy of Approved Pre –Authorization Checklist & Request	
3. Confirmatory Preoperative Laboratory Exams 2Decho	
4. Complete Surgical Operative Report	
5. Complete Anaesthesia Report	
6. Intraoperative TEE Report/ Transthoracic within 3days post op (Attach Result)	
7. MANDATORY CHECKLIST OF SERVICES SIGNED	
8. CLINICAL ABSTRACT Signed by Attending Physician	
9. Completed Z Satisfaction Questionnaire Signed	
10. VSD DATA BASE ENCODED	
11. Completed and signed Philhealth CF2	
DATE COMPLETED :	
DATE FILED :	

CONFORME:

_____ Relation to Patient: _____
Patient/ Guardian
Printed Name and Signature

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH Z MANAGER

_____
Attested by:

_____ _____
Printed Name & Signature
Attending Physician

Printed Name & Signature
Executive Director/Medical Center Chief

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. V (Chief, BELMS)
Date: 2/7/13
CERTIFIED TRUE COPY

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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

TETRALOGY OF FALLOT – ELECTIVE TOF REPAIR

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth: _____
_____
Date of Admission: _____
Date of Discharge: _____

TRANCHE 2 REQUIREMENTS CHECKLIST

II. Second Tranche Payment	Please check
1. Completed PHC- Pediatric Cardiac Rehab Form with 4 sessions Exercise program	
2. Medical certificate of OPD consultation	
3. Postoperative 2Decho result attached	
DATE COMPLETED : DATE FILED :	

CONFORME:

_____ Relation to Patient: _____
Patient/ Guardian
Printed Name and Signature

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH Z MANAGER

_____

Attested by :

_____ _____
Printed Name and Signature
Attending Physician

Printed Name and Signature
Executive Director/Medical Center Chief

PHILHEALTH
MA. TERESA A. DUIAOIT
A.O. IV-Chief, RELMS
Date: 2/7/13
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Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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

Date _____ Date Admitted : _____

Name of Hospital _____ Date Discharged: _____

Name of Patient _____

Phill Health ID Number _____

TETRALOGY OF FALLOT – ELECTIVE TOF REPAIR
CHECKLIST OF MANDATORY and OTHER SERVICES

TRANCHE I

(Place a ✓ and indicate status or date done or given)

SERVICES FIRST TRANCHE	Check and Indicate Date Done/ Given	Attested by: (Name & Signature of Attending Physician)
1. Preoprative Laboratory a. CBC with platelet with Blood typing b. Chest X ray c. Na, K, Cl, Ca d. Creatinine e. Protime f. Partial Thromboplastin Time	A._____ B._____ C._____ D._____ E._____ F._____	
2. Preoperative IE Prophylaxis: a. Vancomycin b. Amikacin	_____ _____	
3. Procedure done (D3) Repair of Tetralogy of Fallot VSD Patch Closure With RVOT Patch Or with Infundibulectomy	RVS code: _____ Date of Procedure : _____	Peds TCV Surgeon : _____ CV Anesthesiologist : _____ Peds Cardiologist : _____

4. Anaesthesia (Check or N.A if not applicable) a. Sevoflorane b. Fentanyl c. Midazolam d. Atropine e. Ketamine f. Esmeron g. Dexamethasone h. Calcium gluconate i. Sodium bicarbonate j. Potassium Chloride k. Magnesium Sulfate l. Heparin m. Protamine sulphate n. Dopamine o. Dobutamine p. Nitroglycerine q. Milrinone	Check if applicable and place Status/date or indicate N.A A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ M. _____ N. _____ O. _____ P _____ Q. _____	CV Anesthesiologist : _____
5. Intraoperative Transesophageal Echo or Transthoracic echo within 48 hours postop (Attach Result)	_____	
6. Blood Transfusion Support (if applicable) ☐ FWB ☐ PRBC ☐ FFP	_____	
7. Ventilatory support at least 6 hours	_____	
8. Postoperative Laboratory: 8.1. 1st 6 Hours postop a. CBC with platelet b. Chest Xray (portable) c. PT d. PTPA e. Na, K, Ca f. ABG's 8.2. Postop 5th-7th day (Pre-discharge): a. CBC b. Chest Xray (PAL)	A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ A. _____ B. _____	

TETRALOGY OF FALLOT TRANCHE I

9. Postoperative Medications a. Dopamine b. Dobutamine c. Nitroglycerine drip d. Milrinone e. Calcium Gluconate f. Tramadol g. Midazolam (sedation) h. Ranitidine i. Oral Digoxin j. Oral Furosemide k. Oral Captopril l. Oral Paracetamol or Ibuprofen m. Oral Antibiotics _____	Check if applicable and place Status/date or NA [ ] A._____ [ ] B._____ [ ] C._____ [ ] D._____ [ ] E._____ [ ] F._____ G._____ H._____ I._____ J._____ [ ] K._____ [ ] L._____ [ ] M._____	

CONFORME:

_____
Parent/Legal Guardian of Patient
Printed Name and Signature

Relation to Patient : _____

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH Z MANAGER

Attested by:

_____
Name and Signature of Attending Physician

_____
Name and Signature of Executive Director/
Medical Center Chief

TETRALOGY OF FALLOT TRANCHE I

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief, RELMS
Date: 2/7/13
CERTIFIED TRUE COPY

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

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief, BELMS
Date: 2/7/13
CERTIFIED TRUE COPY

DATE: _____

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
VENTRICULAR SEPTAL DEFECT (VSD) CLOSURE

(Place a ✓or N.A)

QUALIFICATIONS	Yes	Attested by Attending Physician
1. Age at least 1 year old – 5 years + 364 days	☐	

DIAGNOSTICS	Yes	Date done	Attested by Pediatric Cardiologist
Check 2D Echocardiogram[1]: a. Verify Ventricular Septal Defect perimembranous, subaortic or subpulmonic b. **NO** combined shunts such as Atrial Septal Defect or Patent Ductus Arteriosus Or atrioventricular septal defect c. **NO** other associated CHD's : such as Coarctation of the aorta, or Moderate to severe aortic insufficiency, or Moderate to severe Pulmonic Stenosis d. Pulmonary arterial pressure (PAP) normal, mild to moderate or at least 2/3 the systolic blood pressure	☐ ☐ ☐ ☐	At least within 6 months from date of application _____	

[1]Please attach OFFICIAL 2D ECHO RESULTS

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief, PELMS
Date: 2/7/13
CERTIFIED TRUE COPY

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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

VENTRICULAR SEPTAL DEFECT – ELECTIVE VSD CLOSURE

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth:_____

Date of Admission: _____
Date of Discharge: _____

TRANCHE I REQUIREMENTS CHECKLIST

I. First Tranche Payment	Please Check
1. Copy of Completed ME FORM	
2. Copy of Approved Pre – Authorization Checklist & Request	
3. Confirmatory Preoperative Laboratory Exams 2Decho	
4. Complete Surgical Operative Report	
5. Complete Anaesthesia Report	
6. Intraoperative TEE Report/ Transthoracic within 3days post op (Attach Result)	
7. MANDATORY CHECKLIST OF SERVICES SIGNED	
8. CLINICAL ABSTRACT Signed by Attending Physician	
9. Completed % Satisfaction Questionnaire Signed	
10. VSD DATA BASE ENCODED	
11. Completed and signed Philhealth CF2	
DATE COMPLETED : DATE FILED :	

CONFORME:

_____ Relation to Patient: _____
Patient/ Guardian
Printed Name and Signature

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH % MANAGER

_____
Attested by:

_____ _____
Printed Name & Signature Printed Name & Signature
Attending Physician Executive Director/Medical Center Chief

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. V/ CHEV RELMS
Date: 2/7/13
CERTIFIED TRUE COPY

Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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

VENTRICULAR SEPTAL DEFECT – ELECTIVE VSD CLOSURE

Name: _____ Age: ____Sex ____ PhilHealth No. _____
Address: _____ Date of Birth: _____
_____
Date of Admission: _____
Date of Discharge: _____

TRANCHE 2 REQUIREMENTS CHECKLIST

II. Second Tranche Payment	Please check
1. Completed PHC- Pediatric Cardiac Rehab Form with 4 sessions Exercise program	
2. Medical certificate of OPD consultation	
3. Postoperative 2Decho result attached	
DATE COMPLETED : DATE FILED :	

CONFORME:

_____ Relation to Patient: _____
Patient/ Guardian
Printed Name and Signature

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH Z MANAGER

Attested by :

_____ _____
Printed Name and Signature
Attending Physician

Printed Name and Signature
Executive Director/Medical Center Chief

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. V - RELMS
Date: 2/7/19
CERTIFIED TRUE COPY

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

Date _____ Date Admitted : _____

Name of Hospital _____ Date Discharged: _____

Name of Patient _____

PhilHealth ID Number _____

VENTRICULAR SEPTAL DEFECT
CHECKLIST OF MANDATORY and OTHER SERVICES

TRANCHE I

(Place a ✓ and indicate status or Date done or given)

SERVICES FIRST TRANCHE	Check and Indicate Date Done/ Given	Attested by: (Name & Signature of Attending Physician)
1. Preoprative Laboratory a. CBC with platelet with Blood typing b. Chest X-ray c. Na, K, Cl, Ca d. Creatinine e. Protime f. Partial Thromboplastin Time	☐ A._____ ☐ B._____ ☐ C._____ ☐ D._____ ☐ E._____ ☐ F._____	
2. Preoperative IE Prophylaxis: a. Vancomycin b. Amikacin	☐ _____ ☐ _____	
3. Procedure done (D3) VSD Patch Closure	RVS code: _____ Date of Procedure : _____	Pedia TCV Surgeon : _____ CV Anesthesiologist : _____ Pedia Cardiologist : _____

4. Anaesthesia (Check or N.A if not applicable) a. Sevoflorane b. Fentanyl c. Midazolam d. Atropine e. Ketamine f. Esmeron g. Dexamethasone h. Calcium gluconate i. Sodium bicarbonate j. Potassium Chloride k. Magnesium Sulfate l. Heparin m. Protamine sulphate n. Dopamine o. Dobutamine p. Nitroglycerine q. Milrinone	Check if applicable and place Status/date or indicate N.A ☐ A. _____ ☐ B._____ ☐ C._____ ☐ D._____ ☐ E._____ ☐ F._____ ☐ G._____ ☐ H._____ ☐ I._____ ☐ J._____ ☐ K._____ ☐ L._____ ☐ M._____ ☐ N._____ ☐ O._____ ☐ P._____ ☐ Q. _____	CV Anesthesiologist : _____
5. Intraoperative Transesophageal Echo or Transthoracic echo within 48 hours postop (Attach Result)	☐ _____	
6. Blood Transfusion Support (if applicable) ☐ FWB ☐ PRBC ☐ FFP	☐ _____	
7. Ventilatory support at least 6 hours	☐ _____	

8. Postoperative Laboratory: 8.1. 1st 6 Hours postop a. CBC with platelet b. Chest Xray (portable) c. PT d. PTPA e. Na, K, Ca f. ABG's 8.2. Postop 5th-7th day (Pre-discharge): a. CBC b. Chest Xray (PA)	☐ A._____ ☐ B. _____ ☐ C. _____ ☐ D. _____ ☐ E. _____ ☐ F._____ ☐ A. _____ ☐ B. _____	
9. Postoperative Medications a. Dopamine b. Dobutamine c. Nitroglycerine drip d. Milrinone e. Calcium Gluconate f. Tramadol g. Midazolam (sedation) h. Ranitidine i. Oral Digoxin j. Oral Furosemide k. Oral Captopril l. Oral Paracetamol or Ibuprofen	Check if applicable and place Status/date or NA ☐ A._____ ☐ B. _____ ☐ C. _____ ☐ D. _____ ☐ E. _____ ☐ F. _____ ☐ G. _____ ☐ H. _____ ☐ I. _____ ☐ J. _____ ☐ K. _____ ☐ L. _____	

CONFORME :

_____
Parent/Legal Guardian of Patient
Printed Name and Signature

Relation to Patient : _____

Documents Reviewed by:

_____
Printed Name & Signature
PHILHEALTH Z MANAGER

Attested by:

_____
Name and Signature of Attending Physician

_____
Name and Signature of Executive Director/
Medical Center Chief

VENTRICULAR SEPTAL DEFECT TRANCHE I

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. V / Chief, EELMS
Date: 2/7/13
CERTIFIED TRUE COPY

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 _____
Date of Birth _____

PRE-AUTHORIZATION CHECKLIST
CERVICAL CANCER

(Place a √)

QUALIFICATIONS	Yes	No	Attested by Attending Gyne Onco
1. Biopsy result			
2. No previous radiotherapy			
3. No previous chemotherapy			
4. Treatment plan from Gynecologic Oncologist			
5. No uncontrolled co-morbid conditions			

FIGO Clinical Staging	Yes	Date done	Attested by Attending Gynecologic-Oncologist
Stage: (Check √ only one)			
Stage IA1			
Stage IA2			
Stage IB1			
Stage IB2			
Stage IIA1			
Stage IIA2			
Stage IIB			
Stage IIIA			
Stage IIIB			

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. V, Chief-RELMS
Date: 3/7/13
CERTIFIED TRUE COPY

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 FOR CERVICAL CANCER

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 for cervical cancer.

The patient belongs to the following category (tick √ appropriate box):

☐ **NBB**
☐ **FIXED CO-PAY** (chemo, brachy low dose, cobalt or primary surgery)
☐ **FIXED CO-PAY** (chemo, brachy high dose & linear accelerator)

Requested by:

_____
Printed Name & Signature
Attending Gynecologic Oncologist

Noted by:

_____
Printed Name & Signature
Medical Director/Chief of Hospital

(For PhilHealth Use Only)

☐ Approved
☐ Disapproved

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

Date: _____

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV - CHMD/BSMS
Date: 2/7/13
CERTIFIED TRUE COPY

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

Date:_____ Date Admitted: _____
Name of Hospital_____ Date Discharged: _____
Name of Patient_____
PhilHealth ID Number _____

CHECKLIST OF MANDATORY and OTHER SERVICES SURGERY FOR CERVICAL CANCER STAGE IA1 – II A1

TRANCHE 1

(Place a ✓ and indicate status or date done or given)

SERVICES 1st Tranche Surgery for Cervical CA Stage IA1-IIA1	Check and Indicate Date Done/ Given	Physician's Name and Signature	Conforme (patient's signature)
1. Preoperative Laboratory * a. CBC b. Platelet count c. Blood typing d. Chest X-ray e. ECG f. FBS g. Na, K, Cl, Ca h. Creatinine i. AST/ALT j. Pro-time k. Partial Thromboplastin Time l. Urinalysis m. Histopathology n. Imaging: n.1. TV-UTZ n.2. CT Scan or MRI o. Blood support, screening, processing *p.* Cystoscopy *q.* Proctosigmoidoscopy **if needed/if done*	☐ a._____ ☐ b._____ ☐ c._____ ☐ d._____ ☐ e_____ ☐ f._____ ☐ g._____ ☐ h._____ ☐ i._____ ☐ j._____ ☐ k._____ ☐ l._____ ☐ m._____ ☐ n._____ ☐ o._____ ☐ p._____ ☐ q._____		
2. Preoperative antibiotic Prophylaxis: a. Cefuroxime b. Cefoxitin c. Other antibiotics	☐ a. _____ ☐ b. _____ ☐ c. _____	PHILHEALTH MA. TERESA A. QUIAOIT A.O. IV (RELMS) Date: 2/7/17 CERTIFIED TRUE COPY	

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

SERVICES 1st Tranche Surgery for Cervical CA Stage IA1-IIA1	Check and Indicate Date Done/ Given	Physician's Name and Signature	Conforme (patient's signature)
3. Procedure done **For Stage IA1 alone:** Extrafascial/Total Hysterectomy with or without bilateral salpingoophorectomy **For stage 1A2 -1B1:** Radical Hysterectomy with bilateral pelvic lymphadenectomy, paraortic lymph node sampling ☐ Bilateral salpingoophorectomy ☐ transposition of ovaries	Date of Procedure : _____	Gynecologic Oncologist : _____	
4. Blood Transfusion Support (if indicated) ☐FWB ☐PRBC ☐FFP	☐ _____		
5. Postoperative Laboratory : (when indicated, if done) a. CBC with platelet b. ECG c. electrolytes	Check if applicable and place date or NA ☐ a._____ ☐ b. _____ ☐ c._____		
6. Postoperative Medications (as indicated, when needed) a. Analgesics b. Antibiotics c. Hematinics	Check if applicable and place Status/date or NA ☐ a._____ ☐ b. _____ ☐ c. _____	PHILHEALTH MA. TERESA A. QUIAOIT A.O. IV, CHRELMS Date: 2/7/13 CERTIFIED TRUE COPY	
7. Completed and Signed % Satisfaction Questionnaire	☐ _____		
8. Operative Record	☐ _____		

Attested by: **Date:** _____

_____
Name and Signature of Medical Director

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

Date:_____ Date Admitted: _____
Name of Hospital_____ Date Discharged: _____
Name of Patient_____
PhilHealth ID Number _____

CHECKLIST OF MANDATORY and OTHER SERVICES SURGERY FOR CERVICAL CANCER IA1 – II A1

TRANCHE 2

(Place a ✓ and indicate status or Date done or Given)

Documents for 2nd Tranche Surgery for Cervical CA Stage IA1-IIA1	Please check if applicable and indicate date	Name & Signature of Gynecologic Oncologist	Conforme (Signature of Patient)
1. Medical Certificate of the out-patient follow up consultation (within 2 weeks post-op) with written request for outpatient pap smear 3 months from surgery	☐ _____		
2. Histopathology Result (definitive surgery)	☐ _____		

Attested by:

_____
Name and Signature of Medical Director

Date: _____

PHILHEALTH
MA. TERESA A. QUIAOIT
Date: 2/7/13
CERTIFIED TRUE COPY

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

Date_____

Date Admitted: _____
Date Discharged: _____

Name of Hospital_____
Name of Patient_____
PhilHealth ID Number _____

CHECKLIST OF MANDATORY and OTHER SERVICES CHEMOTHERAPY, BRACHYTHERAPY (LOW DOSE) WITH COBALT CERVICAL CANCER

TRANCHE 1

(Place a ✓ and indicate status or date done or given)

SERVICES 1st TRANCHE (Chemo, Low Dose Brachy, Cobalt)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
1. Pre-procedure Laboratory *			
a. CBC	☐ a._____		
b. Platelet count	☐ b._____		
c. Blood typing	☐ c._____		
d. Chest X-ray	☐ d._____		
e. ECG	☐ e._____		
f. FBS	☐ f._____		
g. Na, K, Cl, Ca	☐ g._____		
h. Creatinine	☐ h._____		
i. AST/ALT	☐ i._____		
j. Protime	☐ j._____		
k. Partial Thromboplastin Time	☐ k._____		
l. Urinalysis	☐ l._____		
m. Histopathology	☐ m._____		
n. Imaging:	☐ n._____		
n.1. TV-UTZ			
n.2. CT Scan or MRI			
o. Blood support, screening, processing	☐ o._____	PHILHEALTH MA. TERESA A. QUIAOIT A.O. V Date: 2/7/13 CERTIFIED TRUE COPY	
p. Cystoscopy	☐ p._____		
q. Proctosigmoidoscopy	☐ q._____		

**if needed/ if done*

SERVICES 1st TRANCHE (Chemo, Low Dose Brachy, Cobalt)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
2. Radiation Therapy A. Pelvic Radiation ☐ Pelvic Cobalt B. Brachytherapy ☐ Low dose rate	**Dates of Procedure (start mm/dd/yy – end mm/dd/yy):** _____ **Dates of Procedures mm/dd/yy** _____ _____ _____ _____	Gynecologic Oncologist :_____ Radiation Oncologist : _____ Gynecologic Oncologist :_____ Radiation Oncologist : _____	
3. Chemotherapy A. Pre chemotherapy laboratory exams[4]: 1. CBC 2. Creatinine 3. Mg 4. Urinalysis [4]if indicated and done B. Chemotherapy Medications ☐ 1. Cisplatin ☐ 2. Carboplatin ☐ 3. Others_____ C. Support medications ☐ 1. Anti emetics Ramosetron Granisetron Metoclopramide ☐ 2. G-CSF ☐ 3. Hematinics ☐ 4. Others_____	**Indicate dates done and cycle number I,II,III,IV,V,VI (mm/dd/yy)** ☐ **1.**_____ ☐ **2.**_____ ☐ **3.**_____ ☐ **4.**_____ **Indicate cycle number I,II,III,IV,V,VI and date (mm/dd/yy)** _____ _____ **Indicate dates given and cycle number I,II,III,IV,V,VI (mm/dd/yy)** ☐ **1.**_____ ☐ **2.**_____ ☐ **3.**_____ ☐ **4.**_____	Gynecologic Oncologist :_____	

PHILHEALTH
MA. TERESA QUIAOIT
Date: 2/7/13
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SERVICES 1st TRANCHE (Chemo, Low Dose Brachy, Cobalt)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
4. Blood Transfusion Support (if indicated) ☐FWB ☐PRBC ☐FFP	☐ _____		
5. Post treatment Medications (home medications, if indicated) a. Anti emetics b. Analgesics c. Hematinics d. Others	**Check if applicable and place Status/date or NA** ☐ **a.**_____ ☐ **b.** _____ ☐ **c.** _____ ☐ **d.**_____		
6. Completed and Signed Z Satisfaction Questionnaire	☐ _____		
7. Radiation Treatment Summary A. Pelvic Radiation (cobalt) B. Brachytherapy (low dose)	☐ **A.**_____ ☐ **B.** _____	Radiation Oncologist: _____	
8. Chemotherapy Treatment Summary and indicate no. of cycles completed I,II,III,IV,V,VI (at least 3 completed cycles)	☐ **I**_____ ☐ **II**_____ ☐ **III**_____ ☐ **IV**_____ ☐ **V**_____ ☐ **VI**_____	Gynecologic Oncologist: _____	

Attested by:

_____
Name and Signature of Medical Director

Date: _____

PHILHEALTH
IMA. TERESA A. QUIAOIT
A.O. IV
Date: 2/7/13
CERTIFIED TRUE COPY

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

Date _____ Date Admitted: _____
Name of Hospital_____Date Discharged: _____
Name of Patient_____
PhilHealth ID Number _____

CHECKLIST OF MANDATORY and OTHER SERVICES CHEMOTHERAPY, BRACHYTHERAPY (LOW DOSE) WITH COBALT CERVICAL CANCER

TRANCHE 2

(Place a ✓ and indicate status or Date done or Given)

DOCUMENT 2ND TRANCHE	Please check if applicable and indicate date	Name & Signature of Gynecologic Oncologist	Conforme (Patient's Signature)
1. Medical Certificate of Out-Patient Follow up Consultation (Within 2 weeks post-procedure) with written request for out-patient pap smear 3 months post-procedure	☐ _____		

Attested by:

_____
Name and Signature of Medical Director

Date: _____

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV (Med. RELMS)
Date: 2/7/17
CERTIFIED TRUE COPY

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

Date:_____ Date Admitted: _____
Name of Hospital_____ Date Discharged: _____
Name of Patient_____
PhilHealth ID Number _____

CHECKLIST OF MANDATORY and OTHER SERVICES CHEMOTHERAPY, HIGH DOSE BRACHYTHERAPY AND LINEAR ACCELERATOR FOR CERVICAL CANCER TRANCHE 1

(Place a ✓ and indicate status or Date done or Given)

SERVICES 1st TRANCHE (Chemorad + Linear Accelerator)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
1. Pre-procedure Laboratory * a. CBC b. Platelet count c. Blood typing d. Chest X-ray e. ECG f. FBS g. Na, K, Cl, Ca h. Creatinine i. AST/ALT j. Protime k. Partial Thromboplastin Time l. Urinalysis m. Histopathology n. Imaging: n.1. TV-UTZ n.2. CT Scan or MRI o. Blood support, screening, processing p. Cystoscopy q. Proctosigmoidoscopy **if needed/ if done*	☐ a._____ ☐ b._____ ☐ c._____ ☐ d._____ ☐ e_____ ☐ f._____ ☐ g._____ ☐ h._____ ☐ i._____ ☐ j._____ ☐ k._____ ☐ l._____ ☐ m._____ ☐ n._____ ☐ o._____ ☐ p._____ ☐ q._____		

PHILHEALTH
MA. TERESA A. QUIAOIT
Date: 2/7/13
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SERVICES 1st TRANCHE (Chemorad + Linear Accelerator)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
2. Radiation Therapy 1. Pelvic Radiation ☐ Linear Accelerator 2. Brachytherapy ☐ High dose rate	**Dates of Procedure (start mm/dd/yy – end mm/dd/yy):** _____ **Dates of Procedures mm/dd/yy** _____ _____ _____ _____	Gynecologic Oncologist :_____ Radiation Oncologist :_____ Gynecologic Oncologist :_____ Radiation Oncologist :_____	
3. Chemotherapy A. Pre chemotherapy laboratory exams† 1. CBC 2. Creatinine 3. Mg 4. Urinalysis †when indicated, if done B. Chemotherapy Medications ☐ 1. Cisplatin ☐ 2. Carboplatin ☐ 3. Others_____ C. Support medications† ☐ 1. Anti emetics Ramosetron Granisetron Metoclopramide ☐ 2. G-CSF ☐ 3. Hematinics ☐ 4. Others_____ †when indicated	**Indicate dates done and cycle number I,II,III,IV,V,VI (mm/dd/yy)** ☐ 1._____ ☐ 2._____ ☐ 3._____ ☐ 4._____ **Indicate cycle number I,II,III,IV,V,VI and date (mm/dd/yy)** _____ _____ **Indicate dates given and cycle number I,II,III,IV,V,VI (mm/dd/yy)** ☐ 1._____ ☐ 2._____ ☐ 3._____ ☐ 4._____	Gynecologic Oncologist :_____ PHILHEALTH MA. TERESA V. QUIAOIT A.O. IV (Clerk III) Date: 2/7/13 CERTIFIED TRUE COPY	

SERVICES 1st TRANCHE (Chemorad + Linear Accelerator)	Check and Indicate Date Done/ Given	Physician's Name & Signature	Conforme (Patient's Signature)
4. Blood Transfusion Support (if indicated) ☐PWB ☐PRBC ☐FFP	☐ _____		
5. Post treatment Medications* (home medications, if indicated) a. Anti emetics b. Analgesics c. Hematinics d. Others	**Check if applicable and place Status/date or NA** ☐ **a.**_____ ☐ **b.** _____ ☐ **c.** _____ ☐ **d.**_____		
6. Completed and Signed Z Satisfaction Questionnaire	☐ _____		
7. Radiation Treatment Summary A. Pelvic Radiation (linear accelerator) B. Brachytherapy (high dose)	☐ **A.**_____ ☐ **B.** _____	Radiation Oncologist: _____	
8. Chemotherapy Treatment Summary and indicate no. of cycles completed I,II,III,IV,V,VI (at least 3 completed cycles)	☐ **I**_____ ☐ **II**_____ ☐ **III**_____ ☐ **IV**_____ ☐ **V**_____ ☐ **VI**_____	Gynecologic Oncologist: _____	

*when indicated

Attested by:

_____
Name and Signature of Medical Director

Date: _____

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. V
Date: 2/7/13/18
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Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Date _____ Date Admitted: _____
Name of Hospital_____Date Discharged: _____
Name of Patient_____
PhilHealth ID Number _____

CHECKLIST OF MANDATORY and OTHER SERVICES CHEMOTHERAPY, HIGH DOSE BRACHYTHERAPY WITH LINEAR ACCELERATOR FOR CERVICAL CANCER

TRANCHE 2

(Place a ✓ and indicate status or Date done or Given)

DOCUMENT 2ND TRANCHE	Please check if applicable and indicate date	Name & Signature of Gynecologic Oncologist	CONFORME (Patient's Signature)
Medical Certificate of Out-Patient Follow up Consultation : (Within 2 weeks post-procedure) with written request for out-patient pap smear 3 months post-procedure	☐ _____		

Attested by:

_____
Name and Signature of Medical Director

Date: _____

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV
Date: 2/7/13
CERTIFIED TRUE COPY