*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. 012 , -2014

TO : **ALL PHILHEALTH MEMBERS, PHILHEALTH ENGAGED GOVERNMENT HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **Z BENEFIT RATES FOR SELECTED ORTHOPEDIC IMPLANTS**

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## I. RATIONALE

In the latest update of the Philippine National Health Accounts covering 2007 – 2010, more than half of the total expenditure for health care came from out of pocket payments. Only 8.9% is shouldered by the social health insurance.

While PhilHealth reimburses hospitalization expenses for surgeries, the cost of medical devices are usually not completely covered and thus, become out of pocket payments by members.

For orthopedic surgeries, the bulk of expenses are made up by implantable devices. The high cost of the devices pushes patients to stay longer in the hospital. Some even refuse treatment for financial reasons. In the elderly, the delay of surgery may increase mortality rate by 30%. This results in productivity losses, lost earnings and lost household production.

Consistent with Republic Act No. 10606, otherwise known as the National Health Insurance Act of 2013, which stipulates granting of benefits for devices, and pursuant to Board Resolution No. 1787 s. 2013, PhilHealth shall cover expenses for specialized medical devices.



## II. RULES FOR IDENTIFIED TYPE Z

1. The provision of selected orthopedic implants shall be covered under the benefit package and only those cases that strictly fulfill the selections criteria shall be covered;

2. All patients for admission to the contracted hospitals must first be screened for qualification to the Z benefits. If qualified, these patients shall at all times be permitted to avail of the benefit package.

3. Pre-authorization from PhilHealth based on the approved selections criteria for the provision of selected orthopedic implants shall be required prior to availment of services except for emergency cases of acute hip fracture requiring multiple screw fixation (MSF).

The contracted hospital shall submit the accomplished pre-authorization checklist (Annex A-2 of this circular) of patients with acute hip fracture who have undergone emergency implantation requiring MSF within 2 days after surgery.

Implantation of MSF for acute hip fractures performed on a weekend or public holiday (where submission after two days is not possible), the hospital shall submit the pre-authorization checklist on the next working day after the weekend or holiday.

It is the hospital's responsibility to ensure that the patient is eligible during the time of the implantation;

All requests for pre-authorization shall be accomplished completely by the contracted hospitals and submitted to the Head of the Regional Benefits Administration Section (BAS) for final approval.

4. The fulfillment of the approved selections criteria shall be the basis for approval of the pre-authorization request;

5. Payment for this package shall be made to the contracted hospitals in full upon filing of claims for the specialized medical devices within 60 days from the date the claim was filed;

6. The No Balance Billing (NBB) Policy shall apply. Negotiated fixed co-pay shall be applied for eligible members and their qualified dependents except those belonging to the indigent, sponsored and household help member categories.

   If the eligible members or their qualified dependents refuse to avail the NBB policy and instead prefer to pay the fixed co-pay, they will be allowed to do so provided they sign a waiver that they are willing to pay the negotiated fixed co-pay instead of availing the NBB policy of the benefit package which is accorded to sponsored program members.

   **In no instance shall the fixed co-pay exceed the rate of the specialized medical devices;**

7. The professional fees for the orthopedic surgeries of the Z benefit package shall follow the professional fees prescribed in corresponding procedure case rates. Rules on pooling of professional fees for government facilities shall still apply;

8. Patients enrolled in the Z benefits shall be deducted a maximum of five (5) days from the 45 days annual benefit limit and such deductions shall be made only on the current year during the fixation of the implant. In cases where the remaining annual benefit is less than five (5) days, the member shall remain eligible to avail of the Z benefit, provided the premiums are updated; no further deduction will be made for the duration of the hospitalization the patient availing the Z benefit;

9. Those who will avail of this Z benefit for specialized medical devices shall not be eligible for the same procedure in the same site for the next five (5) years; if warranted, re-admission shall be covered by the benefits on all case rates.

10. All applicable policies on all case rates shall be reflected in a separate issuance;

11. All rates are inclusive of government taxes;

12. The medical devices shall be subject to regulation by the Food and Drug Administration (FDA) of the Philippines;

13. Donated medical devices shall not be covered under the benefit package;

14. Contracted hospitals shall transact only with FDA-licensed medical device establishment, manufacturers or traders and shall execute a Memorandum of Agreement (MOA) specifically for the Z benefit;

15. The medical devices shall be implanted to patients by a PhilHealth-accredited physician certified by the Philippine Board of Orthopedics and practicing in the contracted hospital;

16. All patients availing of the Z benefit for specialized medical devices shall be monitored for all clinically relevant outcomes (i.e. orthopedic and other adverse events) in the next six (6) months. Reports may be subjected to monitoring and post-audit by PhilHealth.

## III. CASE TYPE Z BENEFIT FOR SELECTED ORTHOPEDIC IMPLANTS

The overall package code for the Z benefit for selected orthopedic implants is **Z011.** The following are the corresponding descriptions, orthopedic implants, RVS codes and rates of the package:

1. Implants for hip arthroplasty

| Package Code | IMPLANTS | RVS Codes | Z Package rate (PHP) | Case Rate (PHP) | Rates of implants per side (left or right) (PHP) |
|---|---|---|---|---|---|
| Z011-A | Total Hip Prosthesis , cemented* | 27130 | 103,400 | 53,400 | 50,000 |
| Z011-B | Total Hip Prosthesis , cementless** | 27130 | 169,400 | 53,400 | 116,000 |
| Z011-C | Partial Hip Prosthesis, bipolar | 27125 | 73,180 | 37,180 | 36,000 |

* cemented: 66 years old and above; **cementless: 65 years and 364 days old and below

The following are the selections criteria for hip arthroplasty:

a. Signed Member Empowerment Form
b. Clinical features
   i. hip fracture
      1. with avascular necrosis of the femoral head; OR
      2. neglected fracture of the hip; OR
      3. hip fracture with pre-existing cox-arthritis; OR
      4. displaced hip fracture
   ii. with avascular necrosis of the femoral head (FICAT Stage III and IV); OR
   iii. hip dysplasia (CROWE I-IV); OR
   iv. severe osteoarthritis; OR
   v. severe inflammatory joint disease (rheumatoid, gout, psoriatic, ankylosing spondylitis)
c. Pre-injury status: ambulatory patients
d. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
      ASA I – normal healthy patient
      ASA II - Patient with mild systemic disease; no functional limitation

2. Implants for hip fixation

| Package Code | IMPLANTS | RVS Codes | Z Package rate (PHP) | Case Rate (PHP) | Rates of implants per side (left or right) (PHP) |
|---|---|---|---|---|---|
| Z011-D | Multiple screw fixation (MSF)*** 6.5mm cannulated cancellous screws with washer | 27235 | 61,500 | 46,500 | 15,000 |

*** 59 years and 364 days old and below (both displaced and undisplaced fracture); 60 years old and above (undisplaced fracture)

The following are the selections criteria for hip fixation:

a. Signed Member Empowerment Form
b. Any hip fracture not covered under the total hip package for femoral neck fracture
   i. with no avascular necrosis of the femoral head; OR
   ii. acute fracture of the hip; OR
   iii. hip fracture with no pre-existing cox-arthritis; OR
   iv. displaced hip fracture
c. Pre-injury status: ambulatory patients
d. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   ASA I – normal healthy patient
   ASA II - Patient with mild systemic disease; no functional limitation



3. Implants for pertrochanteric fracture

| Package Code | IMPLANTS | RVS Codes | Z Package rate (PHP) | Case Rate (PHP) | Rates of implants per side (left or right) (PHP) |
|---|---|---|---|---|---|
| Z011-E | Compression Hip Screw Set (CHS) | 27244 | 69,000 | 46,500 | 22,500 |
| Z011-F | Proximal Femoral Locked Plate (PFLP) | 27244 | 71,000 | 46,500 | 24,500 |

The following are the selections criteria for implants for pertrochanteric fractures:

a. Signed Member Empowerment Form
b. CHS: stable fracture of the intertrochanteric area (AO Classification Type A1 fracture)
c. PFLP: unstable/comminuted pertrochanteric fracture (AO Classification Type A2 and A3 fracture)
d. Pre-injury status: ambulatory patients
e. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   ASA I – normal healthy patient
   ASA II - Patient with mild systemic disease; no functional limitation

4. Implants for Femoral Shaft Fracture

| Package Code | IMPLANTS | RVS Codes | Z Package rate (PHP) | Case Rate (PHP) | Rates of implants per side (left or right) (PHP) |
|---|---|---|---|---|---|
| Z011-G | Intramedullary Nail with Interlocking Screws | 27506 | 48,740 | 30,740 | 18,000 |
| Z011-H | Locked Compression Plate (LCP) - Broad/Metaphyseal/ Distal Femoral LC | 27507 | 50,740 | 30,740 | 20,000 |

The following are the selections criteria for implants for femoral shaft fracture:

a. Signed Member Empowerment Form
b. Femoral shaft fracture
   i. without malignant/metastatic pathologic fracture; AND
   ii. with any complete fracture of the femur

   Pre-injury status: ambulatory patients
c. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   ASA I – normal healthy patient
   ASA II - Patient with mild systemic disease; no functional limitation



## IV. CLAIMS FILING & REIMBURSEMENT

1. The corresponding payment for the packages shall be given in a single tranche.
2. Claims for the Z benefit for specialized medical devices must identify the device and components and must bear a code/serial number by which they and their manufacturer may be explicitly identified.
3. 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).

## V. EFFECTIVITY

This Circular shall take effect for all approved pre-authorizations starting June 1, 2014.

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.

## VI. ANNEXES

1. Pre – authorization checklist and request for Z Benefit for Selected Orthopedic Implants (ANNEXES "A-1" to "A-4")
2. Member Empowerment Form (ME Form) (ANNEX B)
3. Documentary Requirements for claims filing
    a. Discharge checklist (ANNEX C)
    b. Z Satisfaction Questionnaire (ANNEX D)

Please be guided accordingly.

**ALEXANDER A. PADILLA**
President and CEO
Date signed: 4/15/14

UNCONTROLLED COPY
DC: Lynn Date: 5/21/14

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

**Annex A-1**

| |
|---|
| HEALTH CARE INSTITUTION (HCI) |
| ADDRESS OF HCI |
| PATIENT (Last name, First name, Middle name, Suffix) |
| MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix) |
| PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ |

## PRE-AUTHORIZATION CHECKLIST
## Orthopedic Implants: Hip Arthroplasty

(Place a ✓opposite appropriate answer)

| | |
|---|---|
| **SITE OF INJURY** | ☐ Left side ☐ Right side ☐ Both sides |
| **AGE** | ☐ Less than or equal to 65 years and 364 days<br>☐ Age more than or equal to 66 years |

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

UNCONTROLLED COPY Date: 8/21/14 DC: lupd

**ATTESTED BY ATTENDING PHYSICIAN**

(Place a ✓if YES, or NA if not applicable)

| **QUALIFICATIONS** | **Yes** |
|---|---|
| Ambulatory prior to injury | |
| Normal or with mild systemic disease or no functional limitation (ASA I & II) | |

| **CLINICAL FEATURES** | **Yes** |
|---|---|
| Hip fracture presenting with avascular necrosis of the femoral head; or neglected fracture of the hip; or hip fracture with pre-existing cox-arthritis; or displaced hip fracture | |
| For avascular necrosis of the femoral head, necrosis should be classified as FICAT Stage III or IV | |
| Hip dysplasia | |
| Severe osteoarthritis | |
| Severe inflammatory joint disease affected by rheumatoid arthritis, gouty arthritis, psoriatic arthritis or ankylosing spondylitis | |

Attested by Attending Orthopedic Surgeon:

_____
Printed name and signature

**Note: There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.**

*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
### Orthopedic Implants: Hip Arthroplasty

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 (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Fixed Co-pay (indicate amount) Php _____

| Conforme by: | Certified correct by: |
|---|---|
| | |
| (Printed name and signature)<br>Patient/Parent/Guardian | (Printed name and signature)<br>Attending Orthopedic Surgeon |

| Certified correct by: |
|---|
| |
| (Printed name and signature)<br>Executive Director/Chief of Hospital |



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(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

| INITIAL APPLICATION | COMPLIANCE OF REQUIREMENTS |
|---|---|
| Date received by Local Health Insurance Office (LHIO: _____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved): _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ | ☐ APPROVED<br>☐ DISAPPROVED (State Reason/s)<br>_____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved) _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ |

**This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.**

*Republic of the Philippines*
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Healthline 441-7444 www.philhealth.gov.ph

**Annex A-2**

| |
|---|
| HEALTH CARE INSTITUTION (HCI) |
| ADDRESS OF HCI |
| PATIENT (Last name, First name, Middle name, Suffix) |
| MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix) |
| PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ |

## PRE-AUTHORIZATION CHECKLIST
### Orthopedic Implants: Hip Fixation

(Place a ✓opposite appropriate answer)

| | |
|---|---|
| **SITE OF INJURY** | ☐ Left side ☐ Right side ☐ Both sides |
| **AGE** | ☐ Less than or equal to 59 years and 364 days<br>☐ More than or equal to 60 years |

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature



**ATTESTED BY ATTENDING PHYSICIAN**

(Place a ✓if YES, or NA if not applicable)

| **QUALIFICATIONS** | **Yes** |
|---|---|
| Ambulatory prior to injury | |
| Normal or with mild systemic disease or no functional limitation (ASA I & II) | |

| **CLINICAL FEATURES** | **Yes** |
|---|---|
| Hip fracture without avascular necrosis of the femoral head | |
| Acute fracture of the hip | |
| Hip fracture with no pre-existing cox-arthritis | |
| Displaced hip fracture | |

Attested by Attending Orthopedic Surgeon:

_____
Printed name and signature

**Note: There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.**

*Republic of the Philippines*
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## PRE-AUTHORIZATION REQUEST
### Orthopedic Implants: Hip Fixation

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 (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Fixed Co-pay (indicate amount) Php _____

| Conforme by: | Certified correct by: |
|---|---|
| | |
| (Printed name and signature)<br>Patient/Parent/Guardian | (Printed name and signature)<br>Attending Orthopedic Surgeon |

| Certified correct by: |
|---|
| |
| (Printed name and signature)<br>Executive Director/Chief of Hospital |

UNCONTROLLED COPY
DC: Date: 5/01/14

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(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

| INITIAL APPLICATION | COMPLIANCE OF REQUIREMENTS |
|---|---|
| Date received by Local Health Insurance Office (LHIO: _____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved): _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ | ☐ APPROVED<br>☐ DISAPPROVED (State Reason/s)<br>_____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved) _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ |

**This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.**

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Healthline 441-7444 www.philhealth.gov.ph

**Annex A-3**

| |
|---|
| HEALTH CARE INSTITUTION (HCI) |
| ADDRESS OF HCI |
| PATIENT (Last name, First name, Middle name, Suffix) |
| MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix) |
| PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ |

## PRE-AUTHORIZATION CHECKLIST
### Orthopedic Implants: Pertrochanteric Fractures

(Place a ✓opposite appropriate answer)

| | |
|---|---|
| **SITE OF INJURY** | ☐ Left side ☐ Right side ☐ Both sides |

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

UNCONTROLLED COPY Date: 5/21/14 DC: MM

**ATTESTED BY ATTENDING PHYSICIAN**

(Place a ✓if YES, or NA if not applicable)

| **QUALIFICATIONS** | **Yes** |
|---|---|
| Ambulatory prior to injury | |
| Normal or with mild systemic disease or no functional limitation (ASA I & II) | |

| **CLINICAL FEATURES** | **Yes** |
|---|---|
| Stable fracture of the intertrochanteric area, classified as Type A1 fracture | |
| Unstable/comminuted pertrochanteric fracture classified as Type A2 or A3 fracture | |

Attested by Attending Orthopedic Surgeon:

_____
Printed name and signature

**Note: There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.**

*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
## Orthopedic Implants: Pertrochanteric Fractures

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 (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Fixed Co-pay (indicate amount) Php _____

| Conforme by: | Certified correct by: |
|---|---|
| | |
| (Printed name and signature)<br>Patient/Parent/Guardian | (Printed name and signature)<br>Attending Orthopedic Surgeon |

UNCONTROLLED COPY Date: 5/21/19 DC: by MD

| Certified correct by: |
|---|
| |
| (Printed name and signature)<br>Executive Director/Chief of Hospital |

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(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

| INITIAL APPLICATION | COMPLIANCE OF REQUIREMENTS |
|---|---|
| Date received by Local Health Insurance Office (LHIO: _____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved): _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ | ☐ APPROVED<br>☐ DISAPPROVED (State Reason/s)<br>_____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved) _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ |

**This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.**

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

**Annex A-4**

| |
|---|
| HEALTH CARE INSTITUTION (HCI) |
| ADDRESS OF HCI |
| PATIENT (Last name, First name, Middle name, Suffix) |
| MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix) |
| PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ |

## PRE-AUTHORIZATION CHECKLIST
### Orthopedic Implants: Femoral Shaft Fractures

(Place a ✓opposite appropriate answer)

| | |
|---|---|
| **SITE OF INJURY** | ☐ Left side ☐ Right side ☐ Both sides |

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature



**ATTESTED BY ATTENDING PHYSICIAN**

(Place a ✓if YES, or NA if not applicable)

| QUALIFICATIONS | Yes |
|---|---|
| Ambulatory prior to injury | |
| Normal or with mild systemic disease or no functional limitation (ASA I & II) | |

| CLINICAL FEATURES | Yes |
|---|---|
| Femoral shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the femur | |

Attested by Attending Orthopedic Surgeon:

_____
Printed name and signature

**Note: There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.**

*Republic of the Philippines*
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## PRE-AUTHORIZATION REQUEST
### Orthopedic Implants: Femoral Shaft Fractures

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 (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Fixed Co-pay (indicate amount) Php _____

| Conforme by: | Certified correct by: |
|---|---|
| | |
| (Printed name and signature)<br>Patient/Parent/Guardian | (Printed name and signature)<br>Attending Orthopedic Surgeon |

| Certified correct by: |
|---|
| |
| (Printed name and signature)<br>Executive Director/Chief of Hospital |

UNCONTROLLED COPY Date: 5/21/14 DC: [illegible]

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(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

| INITIAL APPLICATION | COMPLIANCE OF REQUIREMENTS |
|---|---|
| Date received by Local Health Insurance Office (LHIO: _____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved): _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ | ☐ APPROVED<br>☐ DISAPPROVED (State Reason/s)<br>_____<br>Date endorsed to BAS: _____<br>Date (Approved/Disapproved) _____<br>Date endorsed to LHIO: _____<br>Date released to Hospital: _____ |

**This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.**

Annex B

# MEMBER EMPOWERMENT FORM

*Inform, support & empower*

**Instructions:**

1. The healthcare provider shall explain and 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.
7. **For patients availing of the Z MORPH for the fitting of external lower limb prosthesis, write N/A for items B2, B3, C4 and D6.**

A. Member/Patient Information

Name of Patient
Philhealth No.
Current age
Birthday
Sex
Permanent address
Telephone/Mobile No.
Email address



B. Clinical Information

1. Description of condition

2. Applicable Treatment Protocol for Z condition agreed upon with healthcare provider

3. Applicable Alternative Protocol/s for Z condition agreed upon with healthcare provider

C. Treatment Schedule and Follow-up Visit/s

1. Date of initial hospital admission or consult[a] (month/day/year)

[a] This refers to the external lower limb pre-prostheses rehabilitation consult for the Z MORPH

2. Date/s of succeeding hospital admission/s or consults[b] (month/day/year)

[b] This refers to the external lower limb measurement, fitting and adjustments for the Z MORPH

3. Date/s of follow-up visit/s[c] (month/day/year)

[c] This refers to the external lower limb post-prosthesis rehabilitation consult

4. Emergencies ( Write exact date/s with the reason or brief description of the nature of the emergency)

D. Member Education

1. My healthcare provider explained the nature of my condition and the expected outcomes resulting from my condition.
   Yes ___ No ___

2. My healthcare provider explained the treatment options[d].
   Yes ___ No ___
   [d] This refers to the need for pre- and post- external lower limb prosthesis rehabilitation for the Z MORPH

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___

E. 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___

F. Printed Name, Signature, Thumb Print and Date

Signature or Thumb Print of Patient, if unable to write.
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)



G. Contact Philhealth

1. Philhealth Cares
2. Call us at telephone number:
3. Text us:
4. email us:

H. 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.

I. 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 authorize PhilHealth to disclose my personal health information to its contracted partners.

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.

J. Name of Patient, Signature/Thumb Print and Date

Name of Patient
Signature or Thumb Print, if unable to write
Date (Month/Day/Year)

K. 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

check √ one:

___ Spouse
___ Parent
___ Child
___ Next of Kin/Guardian

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

**Annex C**

| |
|---|
| HEALTH CARE INSTITUTION (HCI) |
| ADDRESS OF HCI |
| PATIENT (Last name, First name, Middle name, Suffix) |
| MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix) |
| PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐ |

## DISCHARGE CHECKLIST FOR THE Z BENEFIT
### Orthopedic Implants

(Place a ✓ opposite appropriate answer)

| | |
|---|---|
| **SITE OF INJURY** | ☐ Left side ☐ Right side ☐ Both sides |
| **IMPLANT PROVIDED** | ☐ Total hip prosthesis, cemented<br>☐ Total hip prosthesis, cementless<br>☐ Partial hip prosthesis, bipolar<br>☐ Multiple screw fixation, 6.5 mm cannulated cancellous screws with washer<br>☐ Compression hip screw set<br>☐ Proximal femoral locked plate<br>☐ Intramedullary nail with interlocking screws<br>☐ Locked compression plate – broad, metaphyseal, distal femoral |



(place a ✓ if YES)

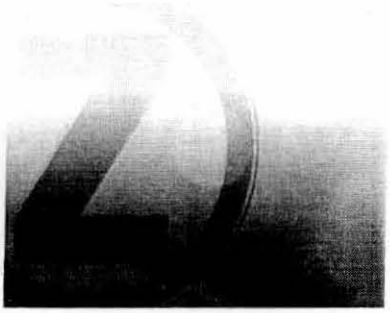
| MANDATORY SERVICES | Status |
|---|---|
| 1. Orthopedic implant/s provided is/are as prescribed. | |
| 2. The individual code/serial number of each of the implants used is indicated in the Operative Technique of the patient. | |
| 3. The discharge plan is given and explained to the patient. | |

| Conforme by:: | Certified correct by: |
|---|---|
| _____<br>(Printed name and signature)<br>Patient/Parent/Guardian | _____<br>(Printed name and signature)<br>Attending Orthopedic Surgeon |
| Date signed: | Date signed: |

**This form should be submitted with the following:**

- ☐ Claim Form I
- ☐ Claim Form II
- ☐ Z Satisfaction Questionnaire
- ☐ Operative Technique (photocopy)

Annex D



# Share your opinion with us!

**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
   - ☐ Cervical Cancer
   - ☐ Coronary Bypass
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for Ventricular Septal Defect
   - ☐ Fitting of external lower limb prosthesis
   - ☐ Orthopedic implants

2. Respondent'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 or supplies needed for the treatment of your condition?
   - ☐ adequate
   - ☐ inadequate
   - ☐ 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!