

PHILHEALTH CIRCULAR
No. 018, s. 2014

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

SUBJECT : **"PD FIRST" Z BENEFITS: THE Z BENEFITS FOR
END-STAGE RENAL DISEASE REQUIRING PERITONEAL
DIALYSIS**

I. BACKGROUND

Chronic kidney disease affects more than 10% of the world's population. Majority of end-stage renal disease (ESRD) among Filipinos is secondary to complications of diabetes, hypertension and chronic glomerulonephritis. While most patients with end-stage renal failure need kidney transplantation, renal replacement therapy with adequate dialysis helps replace sufficient kidney function for a patient to survive.

PhilHealth understands the financial burden of Filipinos afflicted with ESRD. Their household income suffers when they struggle with out-of-pocket spending, especially when the annual benefit limit provided by the social health insurance is used up because ESRD patients also need to combat related complications, such as anemia and infections that further aggravate their situation when they are hospitalized for these. Patients then cope by reducing the frequency of dialysis sessions prescribed to them, thereby compromising their need for adequate dialysis.

Policy directions for the Corporation aim for universal coverage. As the burden of ESRD is of public health concern and considering the patient as the utmost priority of PhilHealth, a *Z benefit* that provides adequate renal replacement therapy for ESRD patients is introduced in the country. This is a benefit addressing access, affordability and viability, while ensuring quality care that is at par with current standards of practice, as well as providing financial risk protection by increasing the support value for renal replacement therapy to almost 100%. This is the *PD First Z Benefits*.

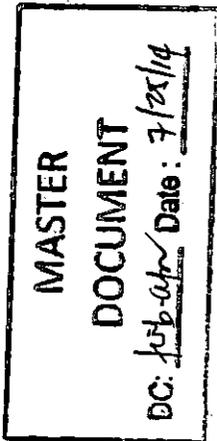
The Corporation has taken a policy of strengthening **peritoneal dialysis first (PD First)** as the initial line of treatment for Filipinos with ESRD requiring renal replacement therapy. It offers better incentive by providing a fixed benefit rate for each patient started and maintained on peritoneal dialysis. The approach to **PD First** also encourages collaboration among relevant stakeholders for quality improvement initiatives and pooled procurement of PD solutions. Hemodialysis, on the other hand, shall be a second line treatment for those not suitable for peritoneal dialysis and an option for patients who shall seek hemodialysis as their preference when their healthcare provider has adequately explained all treatment options to them.

The *PD First Z Benefits* provide total coverage for renal replacement therapy that aims to improve the quality of life of diagnosed ESRD patients in the Philippines.

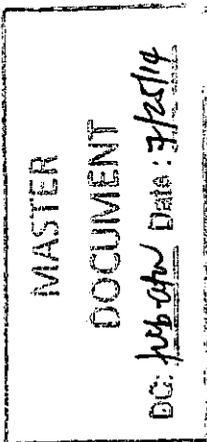
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II. RULES FOR THE *PD First Z Benefits*

- A. Patients with end-stage renal disease (ESRD) who fulfill the selections criteria shall be covered under the *PD First Z Benefits* (Part III, no. 3c of this Circular);
- B. Contracted PD facilities must screen all ESRD patients for qualification to the *PD First Z Benefits*. If qualified, these patients shall at all times be enrolled in this program;
- C. PhilHealth members and their qualified dependents availing of the *PD First Z Benefits* must be eligible at the time of pre-authorization;
- D. Pre-authorization from PhilHealth based on the approved selections criteria shall be required prior to availment of services. All requests for pre-authorization shall be completely and properly accomplished by the contracted PD Provider and submitted to the Head of the Regional Benefits Administration Section (BAS) for approval;
- E. Pre-authorization for the *PD First Z Benefits* of eligible ESRD patients shall be required yearly. A unique case number shall be generated for every pre-authorization request. The *Pre-authorization checklist and request for the PD First Z Benefits* (Annex "A") and the *Member Empowerment Form* or *ME Form* (Annex "B") shall be required for pre-authorization;
- F. No balance billing (NBB) policy shall be applicable as stipulated in PhilHealth Circular 3, series of 2014 (*Strengthening the Implementation of the No Balance Billing Policy*). Negotiated fixed co-pay shall be applied for eligible non-sponsored members and their qualified dependents. The fixed co-pay per year shall not exceed 11% of the package rate. This shall cover for additional services rendered by the PD provider in relation to the PD benefit;
- G. To ensure adequate dialysis and to encourage and to make patients aware that the PD solutions are for their personal use only, patients shall be required to follow-up with their attending PD Provider at least every month without fail. PD solutions shall be given to the patients by the contracted PD provider during such visits at a pre-determined schedule set by the Corporation;
- H. House visits shall be conducted by PD Providers to ensure that patients and their caregivers continue to carry out the proper techniques and standards that should be observed during PD exchanges. Such visits will also serve as a means to assess the adequacy of dialysis and to ensure that PD solutions are used solely by the patients;
- I. Under the *PD First Z Benefits*, the patients shall not be allowed to sell the PD solutions given to them. Patients found liable of selling PD solutions shall forfeit all the privileges of availing benefits under Z, without prejudice to the filing of appropriate charges for possible violation of Section 166 of the Implementing Rules and Regulations of R.A. 7875, as amended. This information must be understood and agreed upon by the patient and must be explained clearly by the PD Provider. The patient signifies his agreement to this provision by affixing his signature in the *Member Empowerment Form* or *ME Form*. (Annex "B")



- J. All mandatory services and supplies under the *PD First Z Benefits* shall be given according to current standards of practice in order to ensure adequate dialysis. Standards of care for peritoneal dialysis shall be established by the Reference Health Care Institution (HCI) and approved by PhilHealth;
- K. PD Providers are required to have a patient logbook and/or electronic medical record of all their PD patients. For standardization, the contents of the electronic medical record shall be set by the Reference HCI and approved by PhilHealth;
- L. The PD Providers shall provide all patients under the *PD First Z Benefits* with a **PD passport**. (Annex "F") This document shall serve as the patient record. PD passports shall only be issued to patients with an approved pre-authorization request that indicates the **unique case number** of each PD patient for tracking purposes. Automation of the PD passport shall be facilitated by the Corporation;
- M. Based on the **PD Passport**, all patients shall be registered by the contracted PD provider according to the system that shall be set by PhilHealth. This system shall ensure that all *PD First Z* patients shall be monitored and tracked for relevant patient outcomes and other parameters set by the Corporation.
- N. The professional fees under the *PD First Z Benefits* are inclusive of the package rate and shall be reflected in the individual contracts of PD providers.
- O. Rules on pooling of professional fees for government facilities shall apply;
- P. Patients enrolled in the *PD First Z Benefits* shall be deducted a maximum of five (5) days from the 45 days annual benefit limit regardless of the actual number of PD exchanges in a calendar year. Such deductions shall be made on the current year when the pre-authorization is approved. In cases where the remaining annual benefit limit is less than five (5) days at the time of pre-authorization, the member shall remain eligible to avail of the *PD First Z Benefits*, provided that premiums are updated;
- Q. Hospital confinements secondary to the nature of the end-stage renal disease condition of patients under the *PD First Z Benefits* shall be covered under the Benefits on All Case Rates or other applicable benefits of PhilHealth;
- R. All claims for the *PD First Z Benefits* shall be filed by the contracted PD provider according to the schedule set by PhilHealth stated in Part IV of this Circular;
- S. The filing of claims shall be done within 60 days from the last day of the period covered;
- T. 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 be released as long as the patient received the scheduled treatment. The remaining tranches shall not be paid;
- U. All rates are inclusive of government taxes;



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- V. Coordination and collaboration with the Reference HCI and among contracted PD Providers shall be required for operational and administrative purposes, such as, but not limited to, **patient referrals, clearance from referring PD provider prior to transfer of patient to other PD providers, patient tracking, pooled procurement of PD solutions, PD trainings, regular patient audits, etc;**
- W. PD patients who wish to transfer to another PD provider shall express their intention by accomplishing the *Letter of Intent for transfer of PD care to a Referral PD provider* (Annex "G") in triplicate. Patients shall submit this letter to their referring PD provider, to the referral PD provider and to the Head of the Benefits Administration Section of the PhilHealth Regional Office which jurisdiction is within the referring PD provider as proof of their intention to transfer.
- X. The PD patients who shall transfer to other contracted PD Providers are required to have a *Checklist for Patient Transfer* (Annex "M") properly accomplished by their referring contracted PD Provider to be submitted to the referral PD provider. The referral PD provider should be notified in advance within a reasonable period of time by the referring PD provider of the plans to transfer a PD patient. The *PD Passport* (Annex "F") shall likewise be required for referrals to other contracted PD Providers to give information as to the record of PD exchanges and the number of bags of PD solutions issued to the patient;
- Y. The contracted PD Provider shall ensure adequate supply of PD solutions to patients and proper inventory to prevent stock-outs;
- Z. All patients 50 years of age and above who are under the *PD First Z Benefits* are eligible to avail of pneumococcal vaccination as stipulated in PhilHealth Circular 7, series of 2014 (*Guidelines for the Oks ang Bakuna ko Laban sa Pulmonya*).

III. THE *PD FIRST Z* BENEFIT RATE, SELECTIONS CRITERIA, AND MANDATORY SERVICES AND SUPPLIES

1. The package code is **Z012**, which includes the current ICD code for end-stage renal disease, which is N18.0 and RVS code for peritoneal dialysis, which is 90945.
2. The package rate shall be P270,000 per year for the entire course of treatment for adequate dialysis;
3. The following are the selections criteria for the *PD First Z Benefits*:
 - a. Patients must have a permanent Tenckhoff peritoneal dialysis catheter properly placed in the abdominal cavity;
 - b. Patients must have completed PD initiation in an accredited healthcare institution so that the patient is no longer uremic, with stable vital signs and adequately trained (patient himself/herself or a caregiver) to perform PD at home using manual exchanges;

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c. Clinical criteria that includes the following:

- i. Must be at least 10 years of age;
- ii. Diagnosed to have end-stage renal disease requiring renal replacement therapy;
- iii. No previous history of cancer other than a successfully and completely-treated cutaneous squamous cell or basal cell carcinoma or carcinoma in-situ of the cervix, within the past 5 years;
- iv. HIV-negative;
- v. No mental incapacity such that informed consent cannot be made or that would interfere with the patient's ability to comply with the PD prescription;
- vi. For pediatric patients, aged 10 to 18 years and 364 days, informed consent from the parents or when appropriate, from the guardian, must be secured;
- vii. Absence of current severe illness including congestive heart failure Class IV, liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension) and chronic lung disease requiring oxygen;
- viii. Absence of hemiparalysis and leg amputation because of peripheral vascular disease;
- ix. No history of substance abuse for at least 3 months prior to start of chronic dialysis treatment;
- x. Absence of any disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen;
- xi. Absence of any inflammatory bowel diseases (ex. Crohns' disease, ulcerative colitis or diverticulitis)
- xii. Absence of any intra-abdominal tumors or intestinal obstruction;
- xiii. Absence of active serositis;
- xiv. Absence of known or suspected allergy to PD solutions

4. The standards of care for the *PD First Z Benefits* set by the Reference HCI and approved by PhilHealth shall reflect the mandatory services and supplies as indicated below:

a. PD supplies as follows

i. PD solutions

- PD double bag system 2.0 liters
- Dextrose concentrations: 1.5%, 2.25% or its equivalent, 4.25%
- Calcium content: Low calcium (1.25mmol/liter) or regular calcium (1.75mmol/liter)

ii. PD accessories

- Transfer set –changed every 6 months only
- Caps (ie., Disconnect cap, Minicap)

b. Number of exchanges

- i. 90 to 120 bags per month according to the PD prescription
- ii. 90 to 120 caps per month according to the number of exchanges prescribed per month

5. The following supplies are **excluded** from the *PD First Z Benefits* package:

- a. Change of transfer set due to contamination
 - b. Y set (ie., Andy disc)
 - c. Use of cyclor for automated peritoneal dialysis
 - d. 5-liter bag PD solutions
6. The payment for this package shall be Two Hundred Seventy Thousand Pesos (P270,000) yearly for complete and adequate dialysis which shall be given in tranches. Every tranche payment should cover the prescribed number of PD exchanges for 14 days for adequate dialysis.

Table 1. Amount per tranche and filing schedule

MODE OF PAYMENT	AMOUNT (Php)	FILING SCHEDULE
In tranches	10,384.60 per tranche	Within 60 days after every 14th day of PD exchanges

IV. CLAIMS FILING

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All claims shall be filed by the contracted PD Providers in behalf of the patients. Claims shall be filed after every 14th day of PD exchanges. The number of exchanges shall be reflected in the *PD First Z Benefits Checklist of Services Provided*. (Annex "C")

Counting of 14 days for the filing of claims will start on the first PD exchange after the medical consultation excluding weekends and holidays. If the deadline of filing of claims falls on a weekend or holiday, the claim shall be filed on the first working day after the weekend or holiday. Consultations and visits to the PD Provider shall be reflected in the *PD Passport* (Annex "F")

Table 2. Sample schedule of filing claims for the *PD First Z Benefits*

Visit to PD Provider	Date	Period Covered	Period to file claim
1 st	July 31, 2014	Aug 1 to 14, 2014	Aug 15 to Oct 13, 2014
2 nd	Aug 14, 2014	Aug 15 to 28, 2014	Aug 29 to Oct 27, 2014
3 rd	Aug 28, 2014	Aug 29 to Sep 11, 2014	Sep 12 to Nov 10, 2014
Etc.	Etc.	Etc.	Etc.

Claim Form 1 shall be submitted for the initial claim. Succeeding claims for the rest of the calendar year shall consist of *Claim Form 2*, the *PD First Z Benefits Checklist of Services Provided* (Annex "C") and the *Tranche Requirements Checklist for the PD First Z Benefits* (Annex "E").

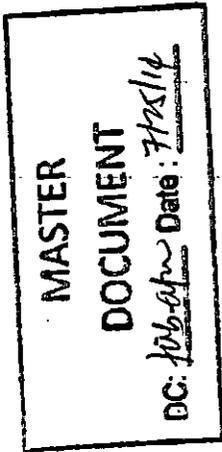
Once a year, PhilHealth shall randomly administer the *Z Satisfaction Questionnaire* (Annex "D") to the PD patient. Results of which may be validated during monitoring, utilization review, post-audit and field validation by PhilHealth and may be used as basis of the Corporation for benefits enhancement, quality improvement and other policy research and development.

V. EFFECTIVITY

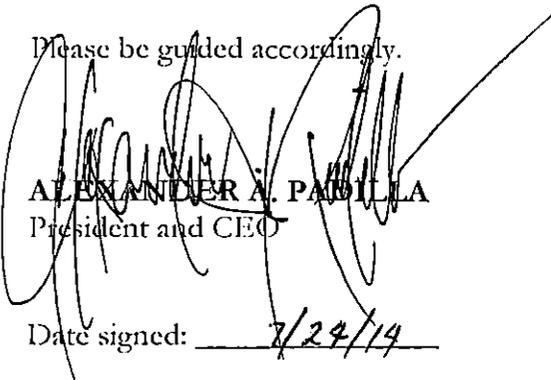
This circular shall become valid and effective after publication in a newspaper of national circulation and deposited thereafter at the National Administrative Register, University of the Philippines Law Center, for all approved pre-authorization starting July 30, 2014 and later.

VI. ANNEXES

1. Pre-authorization checklist and request for the *PD First Z Benefits* (Annex "A")
2. Member Empowerment Form or ME Form (Annex "B")
3. Documentary requirements for claims filing
 - a. Claim Form 1—for the initial claim
 - b. Claim Form 2—for all claim applications
 - c. PD-First Z Benefits Checklist of Services-Provided (Annex "C")
4. Z Satisfaction Questionnaire (Annex "D")—administered by PhilHealth once a year
5. Tranche Requirements Checklist for the *PD First Z Benefits* (Annex "E")
6. PD Passport for the *PD First Z Benefits* (Annex "F")
7. Letter of Intent for Transfer of PD Care to a Referral PD Center (Annex "G")
8. Checklist for Patient Transfer (Annex "M")



Please be guided accordingly.


ALEXANDER A. PABILLA
President and CEO

Date signed: 7/24/14

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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



Case No. _____

Annex "A - PD First"

HEALTH CARE INSTITUTION (HCI)	
ADDRESS OF HCI	
PATIENT (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF PATIENT	<input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF MEMBER	<input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>

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Fulfilled selections criteria Yes *If yes, proceed to pre-authorization application*
 No *If no, specify reason/s _____*

**PRE-AUTHORIZATION CHECKLIST
 PD FIRST Z BENEFITS**

QUALIFICATIONS	(Place a ✓ if YES) YES
Age 10 years and above	
For pediatric patients, aged 10 to 18 years and 364 days, written informed consent from the parents or guardian is secured.	

Conforme by Patient/Parent/Guardian

 Printed name and signature

ATTESTED BY ATTENDING NEPHROLOGIST

QUALIFICATIONS	(Place a ✓ if YES) YES
Diagnosed with end stage renal disease (ESRD) requiring renal replacement therapy	
Has a permanent Tenckhoff peritoneal dialysis catheter properly placed in the abdominal cavity	
Has completed PD initiation in the hospital	
No longer uremic, with stable vital signs	
Patient and/or a caregiver have adequate training to perform PD at home using MANUAL exchanges.	
No previous history of cancer other than a successfully and completely treated cutaneous squamous cell or basal cell carcinoma or carcinoma in-situ of the cervix within the last 5 years	
HIV negative	

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QUALIFICATIONS	YES
No mental incapacity such that informed consent cannot be made or that would interfere with the patient's ability to comply with the PD prescription	
Absence of current severe illness including congestive heart failure Class IV, liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension), and chronic lung disease requiring oxygen, etc.	
Absence of hemiparalysis, leg amputation because of peripheral vascular disease	
No history of substance abuse for at least 3 months prior to start of chronic dialysis treatment	
Absence of any disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen	
Absence of any inflammatory bowel diseases (Crohns' disease, ulcerative colitis or diverticulitis)	
Absence of any intra-abdominal tumors or intestinal obstruction	
Absence of active serositis	
Absence of known or suspected allergy to PD solutions	

Certified correct by Attending Nephrologist:

 Printed name and signature
 PhilHealth Accreditation no. _____

Note:
 Once approved, the contracted HCI shall print the approved pre-authorization form from the HCI Portal and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office or the PhilHealth Regional Office when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during monitoring, post-audit and/or field validation. Please do not leave any item blank.



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Case No. _____

**PRE-AUTHORIZATION REQUEST
 PD FIRST Z BENEFITS**

DATE OF REQUEST (mm/dd/yyyy): _____

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 _____

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Conforme by Patient/Parent/Guardian: (Printed name and signature)	Certified correct by: <i>(for Service Patients)</i> (Printed name and signature)
Certified correct by: (Printed name and signature) Attending Nephrologist PhilHealth Accreditation no. _____	Please tick appropriate box <input type="checkbox"/> Chair, Department of Adult Nephrology OR <input type="checkbox"/> Chair, Department of Pediatric Nephrology OR <input type="checkbox"/> Chair, Department of Organ Transplantation OR <input type="checkbox"/> Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief PhilHealth Accreditation no. _____

(For PhilHealth Use Only)

- APPROVED
 DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			COMPLIANCE OF REQUIREMENTS		
Activity	Initial	Date	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED (State Reason/s)		
Received by Local Health Insurance Office (LHIO):					
Endorsed to BAS:			Activity	Initial	Date
(Approved/Disapproved):			Endorsed to BAS:		
Endorsed to LHIO:			(Approved/Disapproved):		
Released to HCI:			Endorsed to LHIO:		
This pre-authorization is valid for thirty (30) calendar days from date of approval of request.			Released to HCI:		

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 and for PD First Z Benefits, write N/A for items B2 and B3.

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- A. Member/Patient Information
- Name of Patient
 - PhilHealth No. of Patient
 - Name of Member
 - PhilHealth No. of Member
 - 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)

^aThis refers to the external lower limb pre-prosthesis rehabilitation consult for the Z MORPH and the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange

2. Date/s of succeeding hospital admission or consult^b (month/day/year)

^bThis refers to the external lower limb measurement, fitting and adjustments for the Z MORPH and the next visit to the PD Provider for PD First.

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

^cThis 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.
Yes ___ No ___

2. My healthcare provider explained the treatment options^d.
Yes ___ No ___

^dThis 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 ___



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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 ___

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F. Printed Name, Signature, Thumb Print and Date

Signature/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. E-mail 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.

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

Spouse
 Parent
 Child
 Next of Kin/Guardian

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Case No. _____

Annex "C - PD First"

PD FIRST Z BENEFITS CHECKLIST OF SERVICES PROVIDED

CONTRACTED PD PROVIDER	DATE OF CONSULTATION (mm/dd/yyyy)
COVERED PERIOD (mm/dd/yyyy) to (mm/dd/yyyy)	
PATIENT (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF PATIENT	<input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF MEMBER	<input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
ATTENDING NEPHROLOGIST	

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I. PD double bag system 2.0 Liters/bag

Calcium content (tick appropriate box)

Low calcium
 Regular

Number of bags per day: _____

II. PD accessory

Transfer set Quantity: 2 per year, every six (6) months only

Conforme by:	Certified correct by:
_____ Printed name and signature Patient/Parent/Guardian	_____ Printed name and signature Attending Physician/Nephrologist PhilHealth Accreditation no. _____
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)



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.

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DC: *hpb-ghw* Date: *7/25/14*

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:

<input type="checkbox"/> Acute Lymphoblastic Leukemia	<input type="checkbox"/> Coronary Bypass
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Surgery for Tetralogy of Fallot
<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Surgery for Ventricular Septal Defect
<input type="checkbox"/> Kidney Transplant	<input type="checkbox"/> Fitting of external lower limb prosthesis
<input type="checkbox"/> Cervical Cancer	<input type="checkbox"/> Orthopedic implants
	<input type="checkbox"/> PD First Z benefits

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:

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Thank you. Your feedback is important to us!



Case No. _____

Annex "E – PD First"

**TRANCHE REQUIREMENTS CHECKLIST
 PD FIRST Z BENEFITS**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>

(Place a ✓ if attached or NA if not applicable)

MASTER DOCUMENT
 DC: Sub-arr Date: 7/25/14

TRANCHE REQUIREMENTS	Status
I. To be submitted once a year, upon filing claims for the 1 st tranche	
a. Original copy of approved Pre-authorization Checklist and Request	
b. Copy of completely accomplished Member Empowerment (ME) Form	
c. Completed PhilHealth Claim Forms 1* and 2	
II. To be submitted every filing of tranche (every two weeks)	
a. Accomplished Tranche Requirement Checklist	
b. Accomplished PD First Z Benefits Checklist for Services Provided	
III. To be administered by PhilHealth randomly to the patient once a year	
Z Satisfaction Questionnaire	

* not required if pre-authorization is submitted through the HCI Portal

Date Completed:
Date Filed:

Certified correct by:* <hr/> Printed name and signature Attending Nephrologist Accreditation no. _____ <hr/> Date signed (mm/dd/yyyy)	Certified correct by: (for Service patients only) <hr/> Printed name and signature Please tick appropriate box <input type="checkbox"/> Chair, Department/Section of Adult Nephrology OR <input type="checkbox"/> Chair, Department/Section of Pediatric Nephrology OR <input type="checkbox"/> Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief Accreditation no. _____ <hr/> Date signed (mm/dd/yyyy)
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*for CO-PAY PATIENTS, the signature of the Attending Nephrologist is sufficient.

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



Case No. _____

Annex "F – PD First"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>

MASTER DOCUMENT
 DC: Feb - 2014 Date: 7/14/14

**PD PASSPORT
 PD FIRST Z BENEFITS**

Claim Number	Inclusive Dates	PD Exchanges (or bags)/Day	Clearance From Billing (signature)	Pharmacy-dispensing (signature)	Date of Next Claim	Patient's Signature
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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

Case No. _____

Annex "G – PD First"

DATE (mm/dd/yyyy)
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>

MASTER DOCUMENT
 DC: ~~Sub-obj~~ Date: 7/25/14

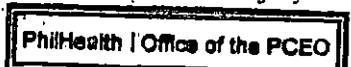
LETTER OF INTENT FOR TRANSFER OF PD CARE TO A REFERRAL PD CENTER

This is to certify that I, _____, born on _____,
 (Name of Patient) (Date of Birth)
 age _____ years old, residing at _____,
 (Address)
 was diagnosed with End Stage Renal Disease and was initiated on peritoneal dialysis at the
 _____ on _____.
 (Name of Referring PD Center) (Date of PD Initiation)

I perform _____ exchanges per day. I would like to request for transfer of PD Care to
 (indicate number)
 _____ under the care of _____.
 (Name of Referral PD Center) (Name of Nephrologist)

I understand that upon transfer to a referral PD Center, I will have to surrender my PD Passport to the PD Coordinator of my referring PD Center as well as waive all my subsequent PD claims in my referring PD Center. In case I decide to return to the referring PD Center to resume my PD Care, I will have to abide by the policies set by them as a new PD patient.

Conforme by:	Certified correct by:
(Printed name and signature) Patient/ Parent/ Guardian	(Printed name and signature) Nephrologist, Referring PD Center PhilHealth Accreditation No. _____
Certified correct by:	Certified correct by:
(Printed name and signature) Billing Representative, Referring PD Center	(Printed name and signature) PD Coordinator, Referring PD Center
Acknowledged by:	Acknowledged by:
(Printed name and signature) Head/PD Coordinator, Referral PD Center	(Printed name and signature) BAS Head, PhilHealth Regional Office _____
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)



Case No. _____

Annex "M - PD First"

**CHECKLIST FOR PATIENT TRANSFER
 PD FIRST Z BENEFITS**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID-NUMBER OF PATIENT <input type="text"/> - <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> - <input type="text"/> - <input type="text"/>

For HCI PD patients* who will be transferred to a referral PD Provider, the following checklist shall be accomplished:

NAME OF REFERRAL PD CENTER
ADDRESS OF REFERRAL PD CENTER

MASTER DOCUMENT
 DC: Sub-ctr Date: 7/23/14

REQUIREMENTS	YES OR NO (tick appropriate box)	SIGNATURE OF RESPONSIBLE PERSON
1. Updated Medical Abstract	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name & signature Attending Nephrologist
2. Updated PD Prescription for one (1) month	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Letter of Referral from Attending Nephrologist/ Fellow	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name & signature Billing Personnel
4. Clearance from PD Provider re status of utilization of PhilHealth PD First Z Benefits Claims	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Letter of Intent from Patient requesting for transfer to a referral PD Provider (Annex G)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name & signature Patient/Parent/Guardian
6. Submission of PD Passport (Annex I ²) to Provider	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name & signature PD Coordinator

* HCI PD Patients are those who had their PD initiation and subsequent follow ups in the referring PD Provider. They claim their PD First Z Benefits from the referring HCI.

Certified complete by: _____	Conforme by: _____
Printed name and signature PD Coordinator	Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)