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PHILHEALTH CIRCULAR
No. 2015 - 035

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

SUBJECT : **THE GUIDING PRINCIPLES OF THE Z BENEFITS**

I. BACKGROUND

The Philippine Health Insurance Corporation (PhilHealth) implemented the Z Benefits on June 21, 2012. These benefits focus on providing relevant financial risk protection against illnesses perceived as medically and economically catastrophic especially affecting Filipinos belonging to the marginalized sectors of society. With the Z Benefits, every patient enrolled in the program is provided quality care that is at par with current standards of practice.

Contracted health care institutions (HCIs) for the Z Benefits shall provide state of the art treatment that can up the survival rate from catastrophic diseases. For instance, in most solid cancers, surgery by trained surgeons is the primary mode of treatment and can be curative in early stages; chemotherapy by medical oncologists/ pediatric oncologists is the primary mode of treatment before and after surgery for these solid cancers; and radiotherapy by trained radiation oncologists is usually used for control and palliative care of cancer. All these emphasize the multidisciplinary-interdisciplinary team approach to patient care, with each discipline respecting the role and expertise of the other, all for the benefit of the Filipino patients who shall be tracked for clinically relevant outcomes. These outcomes shall be used by the Corporation in benefits enhancement, policy research and quality improvement.

Further, the Z Benefits also promote patient empowerment so that patients become active participants in health care decision-making by being informed and educated about their illness as well as their responsibilities in adhering to agreed treatment plans and all these in the background of attaining ultimate patient satisfaction.

Overall, PhilHealth, contracted Health Care Institutions (HCI) and all key stakeholders are partners in the development, implementation and enhancement of the Z Benefits that aim to achieve better health outcomes of patients in order for them to go back to society as productive citizens and to contribute to the economic growth of the country.

II. RATIONALE

In the context of continuous quality improvement, regular evidence update, enhancement of benefits delivery and improvement of the implementation of the Z Benefits, the Corporation came up with these guiding principles. The contents are part of the work in progress of the development and implementation which came into place as an outcome of the policy reviews conducted in collaboration and partnership with key stakeholders. The following provisions in this Circular aim to capture the pertinent inputs from the experts, relevant stakeholders, representatives from the PhilHealth Regional Offices (PROs) and other PhilHealth offices, and most importantly, from the patients who are members of the National Health Insurance Program.

III. OBJECTIVES

A. General Objective

Establish the Guiding Principles of the Z Benefits.

B. Specific Objectives

1. Update the minimum standards of care or the mandatory services based on evidence and current standards of practice that are applicable and transferrable to the local setting;
2. Standardize the forms used for pre-authorization and claims filing;
3. Establish the Z Benefits Information and Tracking System (ZBITS);
4. Institute quality standards, performance indicators and measures for monitoring of the Z Benefits, in collaboration with key stakeholders, experts and the Reference HCIs;
5. Conduct regular policy review of the Z Benefits based on a valid and acceptable methodology;
6. Integrate marketing and promotional activities for the Z Benefits that shall promote and increase public awareness;
7. Promote individual patient empowerment through the Member Empowerment Form (ME Form) by encouraging patient participation in health care decision-making to improve patient adherence to agreed treatment plans in order to achieve good clinical outcomes and patient satisfaction;
8. Emphasize the multidisciplinary-interdisciplinary approach to patient care in partnership with the health care professionals in the contracted HCIs;
9. Introduce the concept of a patient navigation into the Z Benefits in partnership with key stakeholders, experts and patients;
10. Introduce the field monitoring of the Z Benefits;
11. Initiate contracting of the Z Benefits to all capable HCIs.

IV. ESTABLISHING THE **Z BENEFITS INFORMATION AND TRACKING SYSTEM (ZBITS)**

1. The ZBITS is the information tracking system that shall be developed by the Corporation, in collaboration with relevant stakeholders and experts, that aims to track all Z patients in contracted HCIs from diagnosis up to improvement, death or lost to follow-up, and during referral of patients to other contracted HCIs;

2. The ZBITS aims to facilitate the following:

    a) Generation of routine reports, such as, but not limited to, benefits utilization, benefits payment, support value, amount of out-of-pocket payment per patient and per Z condition or per contracted HCI;

    b) Monitoring provision of minimum standards of care (or mandatory services) and other requirements relevant to Z Benefits implementation;

    c) Generation of relevant data which may be useful for policy research and benefits enhancement, actuarial study, planning and marketing, among others;

    d) Determination of clinical outcomes such as survival, morbidity and mortality rates based on local data gathered from contracted HCIs and other outcomes of care that are pertinent to the Corporation, such as patient satisfaction, among others;

    e) Other undertakings in the improvement and future implementation of the Z Benefits.

3. The Modules for the ZBITS shall be included in the HCI Portal during development. Thus, all contracted HCIs are required to have the HCI Portal installed in their facility;

4. The Reference HCIs shall provide PhilHealth the minimum data elements required for patient tracking that are identified to have importance for policy research, benefits enhancements, quality improvement and other undertakings such as the determination of clinical outcomes of care and other factors related to the quality of service provision in all contracted HCIs for the Z Benefits;

5. Once the ZBITS is developed, the data elements identified by the reference HCIs shall be included in the ZBITS Module of the HCI Portal;

6. The HCI shall designate at least one (1) **Z Benefit Coordinator** per Z Benefit Package to access the ZBITS Module.

The guidelines and the specific details of the ZBITS shall be contained in a separate issuance.

V. DESIGNATION OF THE **Z BENEFITS COORDINATOR**

Contracted HCIs shall be required to designate at least one (1) **Z Benefits Coordinator** per Z Benefit Package, whose responsibilities may include, but are not limited to the following, as may be deemed necessary by the contracted HCI:

1. Provide guidance and navigate Z patients by facilitating timely access to the services required for the Z Benefits. Guiding Z patients enrolled in the program aims to overcome health care barriers in the availment of the said benefits in order to ensure patient adherence to agreed treatment plans with the goal of achieving good clinical outcomes and ultimate patient satisfaction;

2. Coordinate with PhilHealth relevant matters pertinent to the Z Benefits availment of candidate patients such as filling out of forms and eligibility requirements prior to pre-authorization and to provide feedback and other inputs required by PhilHealth;

3. Encode pertinent information (i.e. demographics, etc.) of all patients diagnosed with the illness/condition covered by the Z Benefits, whether or not the patient fulfills the selections criteria for pre-authorization;

4. For patients who fulfilled the selections criteria and with approved Pre-authorization Checklist and Request (Annex "A"), the Z Benefits Coordinator shall encode all other pertinent data elements required;

5. Other duties and responsibilities that may be assigned by the contracted HCI such as ensuring completeness and accuracy of all attachments needed for pre-authorization, claims filing and reimbursement, that shall facilitate the implementation of the Z Benefits.

VI. GENERAL RULES FOR AVAILING THE Z BENEFIT PACKAGES

A. All eligible PhilHealth members are qualified to avail the Z Benefit Packages.

It is the responsibility of all members belonging to the Formal Economy, Informal Sector, self-earning individuals, and iGroup with valid Group Policy Contract (GPC) to regularly update their premium contributions to facilitate benefits availment.

All contracted HCIs should remind these patients to update premium contributions and their member profiles prior to their enrolment into the Z Benefits;

B. A member should have at least one (1) day remaining from the 45-day annual benefit limit upon approval of the pre-authorization checklist and request;

C. The PhilHealth Benefit Eligibility Form (PBEF) shall be the primary proof of benefit eligibility. A PBEF that says "YES" means that the patient is eligible. Submission of other documents such as Member Data Record (MDR), proof of contributions and PhilHealth Claim Form 1 (CF1) shall NOT be required;

D. A PBEF that says "NO" means that the patient MAY NOT be eligible. The HCI Portal shall provide the information for documents to be submitted to PhilHealth. These supporting documents shall be attached to the PBEF;

E. Except for cases covered by the above provision, submission of other documents such as proof of contribution, certificate of eligibility or PhilHealth CF1, in lieu of the PBEF, shall only be allowed in extreme circumstances and only upon the approval of PhilHealth.

VII. RULES ON PRE-AUTHORIZATION

A. Newly diagnosed cases shall be eligible for the Z Benefits. A newly diagnosed case is defined as a first time diagnosis in a patient who has not previously undergone treatment for the exact same condition in the Z Benefit Package that is being availed by the patient. This includes the laterality for applicable conditions. Contracted HCIs shall be responsible for enrolling only newly diagnosed patients into the Z Benefits.

Exemptions in the definition of newly diagnosed cases are end stage renal disease (ESRD) requiring kidney transplantation or peritoneal dialysis, limb amputation requiring external limb prosthesis (Z MORPH), coronary artery disease, congenital heart disease and existing hip conditions requiring surgery, among others, which shall be stated in specific guidelines in the future expansion of the Z Benefits for other catastrophic and special conditions.

B. The approved Pre-authorization Checklist and Request shall be valid for 60 calendar days from the date of approval by PhilHealth unless otherwise specified in the policy for other Z packages. All contracted HCIs are responsible for tracking the validity of their approved pre-authorizations. Contracted HCIs shall inform PhilHealth immediately if pre-authorization requests lapsed. They can, however, submit a new pre-authorization checklist and request, if needed;

C. For the Z Benefits on kidney transplantation, the contracted HCIs may require eligible patients to have a certification from their social service office that such patients can maintain anti-rejection medicines for the next three (3) years.

D. For the Z Benefits on breast cancer, the clinical stage requirements for approval of pre-authorization shall follow the definitions* for early breast cancer:

Table 1. Clinical stages for early breast cancer included in the Z Benefits

CLINICAL STAGE	
Stage 0	Tis (carcinoma-in-situ) N0 M0
Stage IA	T1 (tumor≤20mm) N0 M0
Stage IB	T0 N1mi M0; T1 (tumor≤20mm) N1mi M0
Stage IIA	T0 N1 M0; T1 N1 M0; T2 (tumor>20mm but ≤50mm) N0 M0
Stage IIB	T2 N1 M0; T3 (tumor>50mm) N0 M0
Stage IIIA	T3 N1

*Source: AJCC-NCCN 2014

E. For the Z Benefits on cervical cancer, the pre-authorization and the package rates will be based on the following treatment modalities:

Table 2. Treatment modality for cervical cancer and package rates

TREATMENT MODALITY	PACKAGE RATE
Stages IA1 to IIIB Chemoradiation: chemotherapy, cobalt and brachytherapy (low dose) OR primary surgery for Stage IA1, IA2-IIA1	Php 125,000.00
Stages IA1 to IIIB Chemoradiation: chemotherapy, linear accelerator and brachytherapy (low*/high dose)	Php 175,000.00

*only if high dose brachytherapy is not available in the geographic area of the contracted HCI

F. Once the member complied with the eligibility requirements, the contracted HCI shall proceed with the process of seeking approval for pre-authorization. The pre-authorization process involves the following steps:

1. The contracted HCI must completely accomplish all forms required for pre-authorization prior to submission of the Pre-authorization Checklist and Request (Annex "A");

2. While the submission of the Pre-authorization Checklist and Request is done manually, this, along with the photocopy of the properly accomplished ME Form (Annex "B") shall be submitted to the Local Health Insurance Office (LHIO) or to the office of the Head of the PhilHealth Benefits Administration Section (BAS) in the region;

   Once the ZBITS module for Pre-authorization is automated, the contracted HCI shall submit the Pre-authorization Checklist and Request through the HCI Portal;

3. The PhilHealth Regional BAS Head shall send back to the contracted HCI the approved/disapproved Pre-authorization Checklist and Request within two (2) working days;

4. In the event that the approval for pre-authorization is for an emergency case, the contracted HCI shall submit the accomplished Pre-authorization Checklist and Request of the patient who received the mandatory services within two (2) working days after the provision of those mandatory services.

   Emergency cases identified for the Z Benefits are the following:

   a) Kidney transplantation from a non-living donor;
   b) Hip fixation requiring multiple screw fixation;
   c) Administration of chemotherapy in children with a working diagnosis of acute lymphocytic leukemia (standard risk), provided that appropriate specimen samples, i.e., bone marrow, CSF and blood specimens have

been collected for the timely and accurate diagnosis of the child with leukemia. If the results of the diagnostic tests subsequently show that the patient is not standard risk but high-risk leukemia, PhilHealth shall not withdraw the approved pre-authorization. The basis for reimbursement shall be the pre-authorization diagnosis of standard risk acute lymphocytic leukemia; and

d) Other conditions that shall be specified in the Z Benefits expansion for other catastrophic and special conditions

If the deadline of submission of the Pre-authorization Checklist and Request falls on a weekend or a holiday, the contracted HCI shall comply with submission of requirements on the first working day after the weekend or holiday.

It is the contracted HCI's responsibility to remind the patients to update their premium contributions to ensure that these patients are eligible during the time of provision of the mandatory service/s when the HCI has not yet submitted the pre-authorization request to PhilHealth;

5. If the delay in the submission of the Pre-authorization Checklist and Request is due to natural calamities or other fortuitous events, the contracted HCI shall be accorded an extension period of submission of 60 calendar days;

6. All approved Pre-authorization Checklist and Request shall be valid for 60 calendar days from the date of approval except for kidney transplantation, procedures for coronary artery bypass graft surgery (CABG), surgery for Tetralogy of Fallot (TOF) and ventricular septal defect (VSD), which shall be valid for 180 calendar days; and peritoneal dialysis which shall be valid for 60 calendar days;

7. Patients with approved Pre-authorization Checklist and Request shall automatically be deducted five (5) days from the 45 days annual benefit limit. However, patients with only one (1) day remaining from the 45 days annual benefit limit shall still be eligible to avail of the Z Benefits;

8. Laboratory results shall not be required as attachments to the Pre-authorization Checklist and Request. These should be attached instead in the patient's chart and should be available during field monitoring of the Z Benefits;

9. An approved Pre-authorization Checklist and Request guarantees payment of the initial tranche of the Z Benefit Package provided that the mandatory services for the specified treatment phase are given to the patient and all other PhilHealth requirements are complied with.

VIII. FILING OF CLAIMS FOR THE Z BENEFITS

A. After receipt by the contracted HCI of the approved Pre-authorization Checklist and Request and prior to filing a claim for reimbursement, the contracted HCI must render all the mandatory services (Annex "J") and other services in the context of

the multidisciplinary-interdisciplinary approach to patient care as prescribed in the policy. This requirement shall be strictly observed for all the Z Benefit Packages.

As an example, the Z Benefit for breast cancer requires that the administration of chemotherapy shall be under the services or under the direct supervision of a medical oncologist. Such policy shall be reflected in the forms submitted for claims filing of the Z Benefit for breast cancer that show the signatures of both the surgeon and the medical oncologist.

B. To file a claim for reimbursement, the contracted HCI shall submit a claim application and submit the following to PhilHealth:

1. Transmittal Form (Annex "H") of claims for the Z Benefit Package to be used by the contracted HCI per claim or per batch of claims;

2. Original copy of the approved Pre-authorization Checklist and Request signed by the patient, parent or guardian, and the health care providers who are members of the multidisciplinary-interdisciplinary team managing the patient, as applicable, for the first tranche;

3. Photocopy of the properly accomplished ME Form for the first tranche;

   A copy of the properly accomplished ME Form shall be provided to the patient by the contracted HCI and the original copy should be attached in the patient's chart as a permanent record;

4. PhilHealth Benefit Eligibility Form (PBEF) printout or CF1 attached as proof of eligibility during the pre-authorization process;

5. Properly accomplished PhilHealth CF2 for all tranches;

   a) Part I. Fill out item numbers 1, 2, 3;
   b) Part II. Fill out item numbers 1, 2, 3, 4, 5, 6, 7, 8b, 10;
   c) For Part II, item number 10, all doctors of the multidisciplinary-interdisciplinary team must be PhilHealth accredited and must accomplish this part;
   d) Part IIIA. If without co-pay, check the first box. If with co-pay, check the second box. Completely fill out the required information indicated in the corresponding checked item. Statements of account shall be verified during the field monitoring of the Z Benefits and may be required by the Corporation as needed;
   e) Part IIIB. Accomplish this part;
   f) Part IV. Accomplish this part

6. Checklist of Mandatory Services (Annex "C") for the corresponding tranches of the Z Benefit Package availed;

7. Corresponding Checklist of Requirements for Reimbursements (Annex "E");

8. Results of diagnostic and laboratory tests are NOT required as attachments to the claim. However, these should be attached to the patient's chart and shall be checked during the field monitoring of the Z Benefits;

9. Photocopy of the operative record for surgical procedures for verification, validation and audit purposes;

   For the Z Benefit on orthopedic implants, the sticker for the code/serial number or lot/batch number of the medical device should be attached to the original copy of the operative record before photocopying;

10. Photocopy of the completely accomplished Breast Cancer Medical Records Summary Form (Annex "O") for the second tranche of the Z Benefits for breast cancer.

11. Photocopy of the completely accomplished Z Satisfaction Questionnaire (Annex "D").

C. The contracted HCIs shall file claims according to existing policies of PhilHealth;

D. Rules on late filing shall apply;

E. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the contracted HCI shall be accorded an extension period of 60 calendar days as stipulated in Section 47 of the Implementing Rules and Regulation (IRR) of the National Health Insurance Act of 2013 (Republic Act 7875, as amended);

F. There shall be NO direct filing by members.

IX. EVALUATION OF CLAIMS FOR THE Z BENEFITS

A. A filed claim shall undergo review for the completeness of all forms submitted. Signatures of all attending PhilHealth accredited doctors, who are members of the multidisciplinary-interdisciplinary team, attesting that all the mandatory services were provided to the patient are required;

B. The checklist of the mandatory and other services (Annex "C") per Z Benefit Package are attached;

C. There shall be NO Return to Sender (RTS) for the Z Benefit Packages. It is the contracted HCI's responsibility to make sure that all documents are completely filled out and in order prior to submission to PhilHealth. The PROs and LHIOs have the prerogative not to accept incomplete documents. However, they should directly coordinate with the contracted HCIs regarding the deficiencies in the documents. Once the documents are complete, contracted HCIs can submit these to PhilHealth for payment of claims within the required filing schedule.

D. All claims shall be processed by PhilHealth within 30 working days from receipt of claim provided that all requirements are submitted by the contracted HCI.

(Refer to Annex "E" for the list of checklists of requirements for reimbursement per Z benefit package.)

E. Claims shall be denied payment in the following instances:

1. If a mandatory service was not provided by the contracted HCI;
2. If the required signatures in the forms are missing;
3. Incompletely filled out forms;
4. Incomplete attachments, such as ME Form, Z Satisfaction Questionnaire (except for the PD First Z Benefits), operative record (for orthopedic implants bearing the code/serial number or lot/batch number of the medical device), original copy of the approved Pre-authorization Checklist and Request, and other forms required under the Z Benefit Packages;
5. Late filing.

F. The contracted HCI may apply for motion for reconsideration (MR) for all denied Z Benefit claims based on existing PhilHealth policies.

X. PAYMENT OF CLAIMS FOR THE Z BENEFITS

A. For Tranche 1, only claims with approved Pre-authorization Checklist and Request shall be processed and paid accordingly. Claims for succeeding tranches will be paid provided that the preceding tranche payments were made except for the following:

1. breast cancer patients who completed neo-adjuvant chemotherapy prior to surgery where filing of claims for tranche 2 may precede submission of claims for tranche 1; and,

2. PD First Z Benefits (Z Benefits for end-stage renal disease requiring peritoneal dialysis);

B. All claims shall be PAID TO THE CONTRACTED HCI;

C. The payment for the Z Benefit Package for breast cancer for the complete course of first line surgical and standard anti-cancer drug care excludes radiotherapy. Radiotherapy shall be a separate benefit under All Case Rates. However, all contracted HCIs shall facilitate radiotherapy services for their Z patients, which may be done in other PhilHealth-accredited facilities.

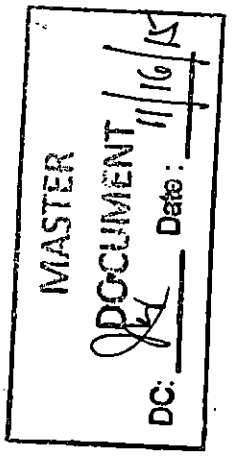

Table 3. Tranche payment, package code, amount and filing schedule for the Z Benefits for breast cancer

TRANCHE PAYMENT	PACKAGE CODE	AMOUNT (Php)	FILING SCHEDULE
Tranche 1	Z0021	75,000.00	Within 60 calendar days after discharge from surgery
Tranche 2	Z0022	25,000.00	Within 60 calendar days upon completion of the last cycle of chemotherapy for Stage I to IIIA For Stage 0, corresponding claims for Tranche 2 may be filed together with claims for Tranche 1. For patients who underwent neo-adjuvant chemotherapy and subsequently underwent surgery, corresponding claims for Tranche 2 may be filed within 60 days upon completion of the last cycle of chemotherapy.

Payment for the first tranche is inclusive of both surgery and initial cycles of standard chemotherapy for Stage I to IIIA or surgery and hormonotherapy with tamoxifen for Stage 0 (DCIS).

The properly accomplished Breast Cancer Medical Records Summary Form (Annex "O") is required for payment of the second tranche for breast cancer.

In the event that a patient expires during the course of chemotherapy or is declared "lost to follow-up", the contracted HCI may still file claims for the payment of the second tranche to PhilHealth but should submit a sworn declaration for all deaths and "lost to follow-up" patients and should completely fill out the Breast Cancer Medical Records Summary Form (Annex "O"), particularly the breast cancer survival status.

In instances that these patients who were declared "lost to follow-up" by the contracted HCI were provided chemotherapy services in other HCIs, claims for the succeeding chemotherapy services for the particular Z package shall be denied.

"Lost to follow-up" means the patient has not come back as advised for immediate next treatment visit or within 12 weeks from last patient-attended clinic visit. Visiting the clinic for a treatment more than 12 weeks from advised scheduled treatment visit renders the patient lost to follow-up.

In instances of bilateral breast cancer, the package rate remains the same. The clinical stage and laterality shall be reflected in the pre-authorization request.

XI. MONITORING OF THE Z BENEFITS

Benefits monitoring of specific Z packages shall be conducted.

This may include field monitoring of specific Z packages provided by contracted HCIs. The method and its corresponding tools and consent forms (Annex "L") are developed for purposes of benefits monitoring, benefits enhancement, policy research and continuous quality improvement.

The performance indicators and measures to monitor compliance to the policies of the Z Benefits of all contracted HCIs shall be established in collaboration with relevant stakeholders and experts. These shall be incorporated in the Health Care Provider Performance Assessment System (HCP PAS) and shall be disseminated in a separate issuance.

XII. POLICY REVIEW

A. A regular policy review of the Z Benefits shall be conducted. The Benefits Development and Research Department (BDRD) of the Health Finance Policy Sector (HFPS) of the Corporation, in collaboration with all relevant stakeholders, experts and technical staff representatives from the PROs, shall take the lead in the policy review process. The methodology (Annex "I") for the initial policy review of the Z Benefits has been established. Improvements to the methodology of the policy review shall be made as necessary based on future thrust and directions of the Corporation. The results of the review shall guide policy decisions regarding benefits enhancements, rates adjustments and future directions pertinent to the Z Benefits.

B. Contracted HCIs may provide PhilHealth the pertinent data for cases which they assessed to be complicated that consequently necessitated the provision of additional services other than those included in the specific Z benefit packages using the form for List of Additional Services (Annex "P"). Data from this form shall be used for policy research and benefits enhancement. This form shall be submitted to the BDRD and a copy thereof shall be provided to the PhilHealth Regional Office concerned. The contracted HCI shall be requested to provide the copy of the complete records of the case for validation purposes.

XIII. MARKETING AND PROMOTION

In order to educate the general public and increase their awareness on Z benefits and to promote informed decision-making and participation among patients, health care professionals, and health care institutions, and other stakeholders marketing and promotional activities shall be undertaken in accordance with the integrated marketing and communication plan of PhilHealth.

The Corporation shall likewise undertake regular monitoring and evaluation of the effectiveness of the marketing and promotion activities of the Z Benefits. Further, patients and stakeholders shall be given the opportunity to participate and contribute

to the improvement of marketing and promotional activities of the Corporation that are pertinent to the Z Benefits.

XIV. CONTRACTING HCIs AS PROVIDERS FOR THE Z BENEFITS

With the mandate of PhilHealth to provide financial risk protection against catastrophic illnesses and to pay for quality health care services, the Corporation has the prerogative to negotiate and enter into contracts with health care institutions and professionals, among others, regarding the pricing and implementation of programs that are pertinent to the delivery of quality health care services in behalf of its members. In this regard, PhilHealth initially engaged with tertiary government HCIs for the provision of specialized multidisciplinary-interdisciplinary health care delivery for the Z Benefits. However, to expand benefit utilization and to increase efficiency of implementation, PhilHealth may contract with other capable government and private HCIs, as long as they follow all the rules of the Z Benefits.

The specific policy and guidelines for contracting capable HCIs and the minimum requirements for renewal of contracts for the Z Benefits are stipulated in PhilHealth Circular 14, s. 2015 (Guidelines for Contracting of HCIs as Z Benefit Package Provider).

XV. REPEALING CLAUSE

All provisions of previous issuances that are inconsistent with any provisions of this Circular are hereby amended/modified/ or repealed accordingly.

XVI. EFFECTIVITY

This circular shall take effect on October 30, 2015 and shall be published in a newspaper of national circulation and deposited thereafter at the National Administrative Register, University of the Philippines Law Center.

XVII. ANNEXES (These annexes shall be uploaded in the PhilHealth website.)

Annex	Label	Description
A	Pre-authorization checklist and request	
	Annex "A-ALL"	Acute lymphocytic/lymphoblastic leukemia [ALL] (Standard risk)
	Annex "A-Breast CA"	Breast cancer, early stage
	Annex "A-CABG"	Coronary artery bypass graft surgery (CABG)
	Annex "A-Cervical CA"	Cervical cancer
	Annex "A-KT"	Kidney transplantation (Low risk)
	Annex "A-MORPH"	Z MORPH (Fitting of external lower limb prosthesis below the knee)

Annex	Label	Description
	Annex "A-Prostate CA"	Prostate cancer (Low to intermediate risk)
	Annex "A-TOF"	Tetralogy of Fallot
	Annex "A-VSD"	Ventricular septal defect
B	Member Empowerment Form	
C	Checklist of Mandatory and Other Services	
	Annex "C1-ALL"	Tranche 1, ALL – Induction Phase
	Annex "C2-ALL"	Tranche 2, ALL – Consolidation, Interim, Maintenance and Delayed Intensification Phase
	Annex "C3-ALL"	Tranche 3, ALL – After 8th Maintenance Cycle
	Annex "C1-Breast CA"	Tranche 1, breast cancer – Post Surgery
	Annex "C2-Breast CA"	Tranche 2, breast cancer – Upon completion of one month hormonotherapy or last cycle of chemotherapy for stages I-IIIA and upon completion of surgery for stage 0
	Annex "C-CABG"	CABG, single tranche only
	Annex "C1.1-Cervical CA"	Cervical cancer, surgery for Cervical Cancer Stage IA1, IA2- IIA1, single tranche only
	Annex "C1.2-Cervical CA"	Cervical cancer, chemoradiation with cobalt and brachytherapy (low dose), single tranche only
	Annex "C1.3-Cervical CA"	Cervical cancer, chemoradiation with linear accelerator and brachytherapy (low/high dose), single tranche only
	Annex "C1-KT" *	Tranche 1, kidney transplantation
	Annex "C2-KT" *	Tranche 2, kidney transplantation – laboratory monitoring for recipient and donor
	* For kidney transplantation, attachments to Annex C1-KT and C2-KT are for the reference of the contracted HCI and which may be used for policy research. PhilHealth shall require submission of these forms; however, the PhilHealth Benefits Administration Section need not assess the clinical contents thereof during claims evaluation.	
	Annex "C-MORPH"	Z MORPH, single tranche only
	Annex "C-Prostate CA"	Prostate cancer, single tranche only
	Annex "C1-TOF"	Tranche 1, TOF
	Annex "C1-VSD"	Tranche 1, VSD
D	Z Satisfaction Questionnaire	
E	Checklists of Requirements for Reimbursement	
	Annex "E1-ALL"	Tranche 1, ALL
	Annex "E2-ALL"	Tranche 2, ALL
	Annex "E3-ALL"	Tranche 3, ALL
	Annex "E1-Breast CA"	Tranche 1, breast cancer
	Annex "E2-Breast CA"	Tranche 2, breast cancer

Annex	Label	Description
	Annex "E1-CABG"	Tranche 1, CABG
	Annex "E2-CABG"	Tranche 2, CABG
	Annex "E1.1-Cervical CA"	Single tranche – Surgery for cervical cancer stage IA1, IA2–IIA1
	Annex "E1.2- Cervical CA"	Single tranche – Cervical cancer, chemoradiation with cobalt and brachytherapy (low dose)
	Annex "E1.3-Cervical CA"	Single tranche – Cervical cancer, chemoradiation with linear accelerator and brachytherapy (low/high dose)
	Annex "E1-KT"	Tranche 1, kidney transplantation
	Annex "E2-KT"	Tranche 2, kidney transplantation
	Annex "E-MORPH"	Single tranche – MORPH
	Annex "E-Prostate CA"	Single tranche – Prostate cancer
	Annex "E1-TOF"	Tranche 1, TOF
	Annex "E2-TOF"	Tranche 2, TOF
	Annex "E1-VSD"	Tranche 1, VSD
	Annex "E2-VSD"	Tranche 2,VSD
F	Refer to PhilHealth Circular No. 18, s. 2014 "Z Benefits on Peritoneal Dialysis (PD First Z Benefits)"	
G		
H	Transmittal Form for the Z Benefits	
I	Methodology for the Policy Review of the Z Benefits	
J	List of mandatory services** for kidney transplantation, breast cancer, prostate cancer, ALL, CABG, TOF and VSD, cervical cancer, selected orthopedic implants **Disclaimer: These mandatory services are the minimum standards of care and may be revised as needed based on updated evidence in the medical literature that is acceptable by current standards of practice and applicable or transferable to the local setting.	
K	Summary of Codes for ALL, breast cancer, prostate cancer, kidney transplantation, CABG, TOF, VSD, cervical cancer, Z MORPH, selected orthopedic implants, PD First	
L	Field monitoring of the Z Benefits (for purposes of benefits monitoring only)	
	Annex "L1"	Methodology for the field monitoring
	Annex "L2"	Informed consent for the interview
	Annex "L3"	Informed consent for the photo and video coverage
	Annex "L4"	Breast cancer treatment data extraction form
	Annex "L-ALL"	Field monitoring tool for patient who availed of the Z Benefits for acute lymphocytic/ lymphoblastic leukemia

Annex	Label	Description
	Annex "L-Surgery"	Field monitoring tool for patient who availed of the Z Benefits for CABG, TOF, VSD, prostate cancer
	Annex "L-Surgery, Chemoradiation"	Field monitoring tool for patient who availed of the Z Benefits for breast cancer and cervical cancer
M	Refer to PhilHealth Circular No. 18, s. 2014 "Z Benefits on Peritoneal Dialysis (PD First Z Benefits)"	
N	Summary of age requirements for the Z Benefits for kidney transplantation, prostate cancer, CABG, VSD, TOF, selected orthopedic implants and peritoneal dialysis	
O	Breast Cancer Medical Records Summary Form	
P	List of Additional Services for Complicated Cases	

Please be guided accordingly.

ALEXANDER A. PADILLA
President and CEO
Date signed: 11/10/16

MASTER DOCUMENT
DC: Date: 11/16/16

SUBJECT: THE GUIDING PRINCIPLES OF THE Z BENEFITS

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Case No. _____

Annex "A – ALL"

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

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

PRE-AUTHORIZATION CHECKLIST
Acute Lymphocytic/Lymphoblastic Leukemia
Standard Risk

Place a check mark (✓)

QUALIFICATION	YES
Age 1 to 10 years and 364 days	

Conforme by Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING PHYSICIAN

Place a check mark (✓)

QUALIFICATIONS	YES
1. Bone marrow aspirate morphology ALL FAB L1 or L2*	
2. No CNS involvement based on:	
a. CSF cell count and differential count	
b. Clinical findings	
3. If male, no testicular involvement	

* L3 morphology is excluded

Place a check mark (✓)

DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
CBC WBC count <50,000/μL or <50,000 cells/μL or <50 x 10^3/μL or <50 x 10^9/L		
CSF cell count white blood cell (WBC) not more than 5 x 10^6/L		

Certified correct by Attending Physician:

Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)

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 HCI)
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)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:
(Printed name and signature) Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

MASTER DOCUMENT Date: 11/10/15 DC:

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Case No. _____

Annex "C1 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Induction Phase

Tranche 1

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

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Diagnostics	
1. Bone marrow aspirate examination (morphologic assessment of BMA smears)	
2. CSF analysis with WBC differential count	
3. CBC (with platelet count)	
4. Alanine aminotransferase (ALT)	
5. Bilirubin	
6. Creatinine	
7. PT/PTT	
8. Electrolytes	
a. Sodium	
b. Potassium	
c. Calcium	
d. Chloride	
e. Magnesium, as needed	
f. Phosphorous, as needed	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
9. Uric acid	
10. Chest X-ray	
11. 2D echocardiography, as needed	
12. Flow cytometric immunophenotyping, as needed	
13. CSF cytospin, as needed	
14. Abdominal ultrasound, as needed	
15. Evaluation of infection (ex. blood culture), as needed	
16. Others, indicate (ex. cytogenetics), as needed	
B. Blood support and processing, as needed	
1. Blood typing	
2. Cross matching	
3. Blood screening	
4. Blood products (packed RBC/platelet concentrate/fresh frozen plasma)	
C. Complete list of medicines given	
1. Chemotherapy	
a. Systemic	
i. vincristine	
ii. L-asparaginase	
iii. doxorubicin (as indicated)	
b. Intrathecal	
i. Single (methotrexate) OR	
ii. Triple (methotrexate, cytarabine, hydrocortisone)	
2. Other drugs (as indicated)	
a. prednisone	
b. diphenhydramine	
c. hydrocortisone	
3. Anti-emetics (as indicated)	
a. ondansetron	
b. metoclopramide	
4. Pain medications (as indicated)	
a. nalbuphine	
b. tramadol	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
5. Anesthetics (as indicated)	
a. ketamine	
b. propofol	
6. Sedatives (prior to procedure, as indicated)	
a. midazolam	
b. diphenhydramine	
7. Antibiotics	
a. cotrimoxazole (as indicated)	
b. ceftriaxone (as indicated)	
c. ceftazidime (as indicated)	
d. amikacin (as indicated)	
e. Other antibiotics based on hospital antibiogram Specify: _____	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No: | | | | | – | | | | | | | – |	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "C2 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Consolidation, Interim Maintenance and Delayed Intensification Phase

Tranche 2

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

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Diagnostics	
1. CSF Analysis WBC differential count	
2. CBC with platelet count	
3. Creatinine	
4. Bilirubin	
5. Bone marrow aspirate examination, as needed	
6. Alanine aminotransferase (ALT), as needed	
7. PT/PTT, as needed	
B. Complete list of medicines given	
1. Chemotherapy	
a. Systemic	
i. vincristine	
ii. doxorubicin	
iii. L-asparaginase (as indicated)	
iv. cytarabine	
v. cyclophosphamide	
vi. methotrexate (IV and oral)	
vii. 6-mercaptopurine	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
b. Intrathecal	
i. Single (methotrexate) OR	
ii. Triple (methotrexate, cytarabine, hydrocortisone)	
2. Other drugs (as indicated)	
a. MESNA	
b. dexamethasone	
c. hydrocortisone	
3. Anti-emetics (as indicated)	
a. ondansetron	
b. metoclopramide	
4. Antibiotics (as indicated)	
a. cotrimoxazole	
b. ceftriaxone	
c. ceftazidime	
d. amikacin	
e. Other antibiotics based on hospital antibiogram Specify: _____	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ____-____-____	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "C3 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
After 8th Maintenance Cycle

Tranche 3

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

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Diagnostics	
1. CSF Analysis WBC differential count	
2. CBC with platelet count	
3. Chest X-ray (as indicated)	
4. Bone marrow aspirate examination, as needed	
5. Alanine aminotransferase (ALT), as needed	
6. Creatinine, as needed	
7. Bilirubin, as needed	
8. Amylase, as needed	
9. Cranial CT scan, as needed	
10. CSF cytospin, as needed	
11. Minimal residual disease by flow cytometry, as needed	

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
B. Complete list of medicines given	
1. Chemotherapy	
a. Systemic	
i. vincristine	
ii. doxorubicin (as indicated)	
iii. methotrexate (oral)	
iv. 6-mercaptopurine	
b. Intrathecal	
i. Single (methotrexate) OR	
ii. Triple (methotrexate, cytarabine, hydrocortisone)	
2. Other drugs (as indicated)	
a. dexamethasone	
b. prednisone	
3. Anti-emetics (as indicated)	
a. ondansetron	
b. metoclopramide	
4. Antibiotics (as indicated)	
a. cotrimoxazole	
b. ceftriaxone	
c. ceftazidime	
d. amikacin	
e. Other antibiotics based on hospital antibiogram Specify: _____	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. | | | | | – | | | | | | | – | |	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "E1 – ALL"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Induction Phase

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-ALL)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-ALL)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Checklist of Mandatory and Other Services (Annex C1-ALL)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER DOCUMENT Date: 11/18/15 DC: ___

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Case No. _____

Annex "E2 – ALL"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
Consolidation, Interim, Maintenance and Delayed Intensification Phase

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-ALL)	
3. Completed PhilHealth Claim Form 2	
4. Checklist of Mandatory and Other Services (Annex C2-ALL)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "E3 – ALL"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 3)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
After 8th Maintenance Cycle

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 3) (Annex E3-ALL)	
3. Completed PhilHealth Claim Form 2	
4. Checklist of Mandatory and Other Services (Annex C3-ALL)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex A – "Breast CA"

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

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

PRE-AUTHORIZATION CHECKLIST
Early Breast Cancer

Place a check mark (✓)

QUALIFICATIONS	**Yes**
1. No previous chemotherapy for breast cancer	
2. No previous radiotherapy for breast cancer	

Place a (✓) if YES

CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions. *Source: AJCC-NCCN 2014)*	**Right**	**Left**
cStage 0: Tis (carcinoma-in-situ) N0 M0		
cStage IA: T1 (tumor≤20mm) N0 M0		
cStage IB: T0 N1mi M0; T1 (tumor≤20mm) N1mi M0		
cStage IIA: T0 N1 M0; T1 N1 M0; T2 (tumor>20mm but ≤50mm) N0 M0		
cStage IIB: T2 N1 M0; T3 (tumor>50mm) N0 M0		
cStage IIIA: T3 N1		

Certified correct by Attending Medical Oncologist:

_____
Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐-☐☐☐☐☐☐-☐

Certified correct by Attending Surgeon:

_____
Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐-☐☐☐☐☐☐-☐

Conforme by Patient:

_____
Printed name and signature

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form 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 (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Early Breast Cancer

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (NAME OF HCI) 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)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) 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		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		

MASTER COPY DOCUMENT

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Case No. _____

Annex "C1– Breast CA"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Early Breast Cancer
Post-Surgery

Tranche 1

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

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Procedure: Total mastectomy or modified radical mastectomy ☐ R breast ☐ L breast ☐ bilateral breast	
B. Diagnostics:	
1. Mammography	
2. Histopathology	
3. ER/PR	
4. Her2 neu test*	
5. CBC with platelet count*	
6. Chest X-ray PAL*	
7. Ultrasound of whole abdomen*	
8. Alkaline phosphatase**	
9. ECG, as needed	
10. Creatinine, as needed	
11. PT/PTT, as needed	

*not required for cStage 0 DCIS
**not required for cStage 0 DCIS, I and IIA

MANDATORY AND OTHER SERVICES	Status
12. CP clearance, as needed	
13. FBS, as needed	
14. Electrolytes, as needed	
a. Sodium	
b. Potassium	
c. Calcium	
d. Phosphate	
15. Urinalysis, as needed	
16. 2D echo, as needed	
17. SGPT, as needed	
18. SGOT, as needed	
19. Complete list of medicines given: (may attach a separate sheet)	

*not required for cStage 0 DCIS
** not required for cStage 0 DCIS, I and II

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Case No. _____

Annex "C2– Breast CA"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Early Breast Cancer
Upon completion of one (1) month hormonotherapy or last cycle of chemotherapy for stages I-IIIA and upon completion of surgery for stage 0

Tranche 2

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

Place a (✓) in the status column if given or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Histopathologic Stage (Indicate): _____	
B. Complete list of medicines given:	
1. Hormonotherapy:	
Tamoxifen	
2. Chemotherapy* (any of the following treatment protocols):	
a. AC	
i. doxorubicin	
ii. cyclophosphamide	
b. CMF**	
i. cyclophosphamide	
ii. methotrexate	
iii. fluorouracil	
c. FAC	
i. fluorouracil	
ii. doxorubicin	
iii. cyclophosphamide	

*not required for Stage 0 DCIS
**for elderly or those with heart disease who cannot tolerate doxorubicin

MANDATORY AND OTHER SERVICES	Status
d. AC + T	
i. doxorubicin	
ii. cyclophosphamide	
iii. docetaxel	
e. TC	
i. docetaxel	
ii. cyclophosphamide	
3. Anti-emetic (as indicated) Name of anti-emetics _____	
4. Antibiotics (as indicated) Name/s of antibiotics _____ _____ _____	
5. Pain relievers (as indicated) Name/s of pain relievers _____	
6. Other medicines: (as indicated) Specify:_____	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Case No. _____

Annex "E1 – Breast CA"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Post-Surgery of Early Breast Cancer

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-Breast CA)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Breast CA)	
4. Photocopy of Completely Accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Checklist of Mandatory and Other Services (Annex C1-Breast CA)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Case No. _____

Annex "E2 – Breast CA"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Upon completion of one (1) month hormonotherapy or last cycle of chemotherapy for stages I-IIIA and upon completion of surgery for stage 0

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-Breast CA)	
3. Completed PhilHealth Claim Form 2	
4. Checklist of Mandatory and Other Services (Annex C2-Breast CA)	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
6. Photocopy of Breast Cancer Medical Records Summary Form (Annex O)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Case No. _____

Annex A – "Prostate CA"

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

PRE-AUTHORIZATION CHECKLIST
Prostate Cancer, low to intermediate risk

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

ATTESTED BY ATTENDING PHYSICIAN

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

QUALIFICATIONS	YES
No previous radiotherapy for prostate cancer	
No uncontrolled co-morbid conditions	
At least 40 years of age	

(Place a ✓if YES)

DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
Stage: Choose only one (1) stage		
(T1a-T2c), PSA level 10 to 20 ng/ml, Tumor Grade (Gleason's score of 2-7)		
Low risk: T1-T2a and Gleason score 2-6, and PSA <10 ng/ml		
Intermediate risk: T2b to T2c, Gleason score of 7, and PSA 10-20 g/ml		
Localized prostate cancer		
Stage IIB T2N1M0 or T3N0M0		
Stage IIIA T0, T1, T2N2MO or T3N1N2M0		

Conforme by Patient/Relative:

_____
Printed name and signature

Certified correct by Attending Physician:

_____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐

Note:

Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the patient or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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Case No. _____

Annex "E – Prostate CA"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Prostate Cancer, low to intermediate risk

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E-Prostate CA)	
3. Photocopy of Approved Pre –Authorization Checklist & Request (Annex A-Prostate CA)	
4. Photocopy of completely Accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Discharge Checklist for Prostate CA (Annex C-Prostate CA)	
7. Photocopy completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED : DATE FILED :	

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

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Case No. _____

Annex "A – KT"

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

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

PRE-AUTHORIZATION CHECKLIST
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

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

QUALIFICATIONS	YES
At least 10 years of age	
On chronic dialysis because of end stage renal disease except for pre-emptive kidney transplantation	

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURGEON

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

QUALIFICATIONS	YES
With irreversible renal disease that progresses to end stage renal disease.	
No previous history of cancer (except basal cell skin cancer).	
If patient is HIV-positive, the HIV-1 RNA viral load should be below detectable levels while on anti-retroviral therapy (<50 copies/mL) and CD4+ count should be >200 cells/mm^3; hepatitis B surface antigen negative; and hepatitis C antibody negative.	
Absence of current severe illness (congestive heart failure class 3-4), liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension), chronic lung disease requiring oxygen, etc.	

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

QUALIFICATIONS	YES
Absence of the following: hemiparalysis, leg amputation because of peripheral vascular disease, mental incapacity such that informed consent cannot be made, and substance abuse for at least 6 months prior to start of transplant work-up.	
For CMV IgG negative recipient, donor should be CMV IgG negative.	

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

DIAGNOSTICS	YES
For pre-emptive kidney transplant and diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 20 mL/min /1.73m^2	
For pre-emptive kidney transplant and non-diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 15 mL/min /1.73m^2	
Low risk: a. Primary kidney transplant (no previous solid organ transplant) b. Historical Past Panel Reactive Antibody (PRA) Class 1 & 2 negative c. If Historical Past Panel Reactive Antibody (PRA) Class 1 and/or 2 is positive, must fulfill the following: c.1 Historical PRA less than or equal to 20% c.2 No donor specific antibody (DSA) in the potential recipient d. Single organ transplant e. Negative tissue crossmatch	

MASTER DOCUMENT DC: Date: 11/16

Certified correct by Attending

Certified Correct by Attending Nephrologist or Transplant Surgeon:

Printed name and signature

PhilHealth Accreditation No. ____ - ____ - ____

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form 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 (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

DATE OF REQUEST (mm/dd/yyyy)

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (NAME OF HCI) 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)
☐ Co-pay (indicate amount) Php _____

Conforme by Patient/Parent/Guardian:	Certified correct by: (for Service Patients)
(Printed name and signature)	(Printed name and signature) Please tick appropriate box ☐ Chair, Department of Adult Nephrology ☐ Chair, Dept. of Pediatric Nephrology ☐ Chair, Department of Organ Transplantation ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
Certified correct by: (Printed name and signature) Attending Nephrologist	
PhilHealth Accreditation No.	PhilHealth Accreditation No.

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY Date: 11/16/16 DOCUMENT

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	Initial	Date	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			Activity	Initial	Date
Released to HCI:			Received by BAS:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Case No. _____

Annex "C1 – KT"

CHECKLIST OF MANDATORY AND OTHER SERVICES
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)
Tranche 1

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

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY AND OTHER SERVICES	Status
A. Cardiology clearance - for donor (if indicated) and recipient	
B. Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates	
C. Transplantation surgery with living or deceased donor	
D. Hemodialysis or peritoneal dialysis during admission for transplantation, if indicated	
E. Immunosuppressant induction therapy, unless identical twin or zero HLA-antigen mismatch	
F. Immunologic risk- Negative tissue crossmatch between donor and recipient, primary kidney transplant, single organ transplant, PRA class 1 and 2 negative or PRA≤20%; no donor specific antibody	
IMMUNOSUPPRESSION OPTIONS (choose 1, 2, 3 or 4 only)	
1. Calcineurin inhibitor + mycophenolate + prednisone with or without induction a. cyclosporine + mycophenolate motetil or mycophenolate sodium + prednisone OR b. tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone	
2. Calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction a. Low-dose cyclosporine + sirolimus + prednisone OR b. Low-dose cyclosporine + everolimus + prednisone	

IMMUNOSUPPRESSION OPTIONS (choose 1, 2, 3 or 4 only)	**Status**
3. Calcineurin inhibitor such as cyclosporine + azathioprine + prednisone with or without induction	
4. Steroid-free for zero HLA-mismatch patient or induction using rabbit antithymocyte globulin	

INDUCTION THERAPIES (choose either 1 or 2)	
1. Interleukin-2-receptor antibody (basiliximab) 20 mg IV for two doses	
2. Lymphocyte depleting agents Rabbit anti-thymocyte globulin 1.0-1.5 mg per kg per day for three doses	

ANTI-REJECTION THERAPY, if indicated Methylprednisolone 500 mg IV per day for three days	

OTHERS	
Graft renal biopsy, if indicated	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Nephrologist or Transplant Surgeon:	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No.	
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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PRE-TRANSPLANT EVALUATION FORM FOR KIDNEY TRANSPLANT RECIPIENT
Attachment to Tranche 1

Please answer all questions completely and accurately. Tick appropriate boxes.

Name (Last, First, MI) _____ ☐ NBB ☐ Fixed Co-Pay

Age ____ Sex ☐ Male ☐ Female Civil Status: ☐ Single ☐ Married ☐ Widow ☐ Separated

Race _____ Hospital No. _____

Permanent Address _____

_____ Tel. No. _____

Present Address _____

_____ Tel. No. _____

Attending Nephrologist _____ Transplant Surgeon _____

Name of Donor (Last, First, MI) _____

PhilHealth ID No. ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Primary Renal Disease _____ ☐ Clinical ☐ Biopsy Proven

Duration of Dialysis _____ Mode of Dialysis ☐ None ☐ HD ☐ PD, specify _____

KT History ☐ 1st ☐ 2nd ☐ Specify, _____ ☐ Other organ grafted _____

Anemia management: ☐ BT, _____ # units Date of last BT _____

☐ EPO, Dose _____

Past Medical/Social History:

☐ HPN ☐ DM ☐ Asthma ☐ Renal Stone ☐ COPD ☐ # of Previous Pregnancies

☐ CAD ☐ Stroke ☐ PVD ☐ Liver Disease ☐ Lupus

☐ Splenectomy ☐ Others, specify _____

☐ Previous Surgeries _____ ☐ Allergies _____

☐ Smoking (Pack years) _____ ☐ Alcohol Intake _____

Family history ☐ HPN ☐ DM ☐ CAD ☐ Others, specify _____

PRE-TRANSPLANT TESTS *(recent laboratory tests and indicate dates)*

Hematology (___/___/___)

*WBC_____ *Hgb_____ *Hct _____ *Platelet _____ *Bleeding Time _____ *PT _____ *PTT _____

Blood Chemistries (___/___/___)

*Crea _____ BUN_____ *FBS _____ *Chole _____ *Trig _____ *Uric Acid _____

*ALP _____ SGOT _____ *SGPT _____ *Albumin _____ *Ca _____ *P _____

*K _____ *Na _____ Intact PTH _____

Urine Examination (___/___/___) Defer if patient if anuric

*Sp. Gr. _____ pH _____ Protein_____ Sugar____ Blood_____ WBC_____ RBC_____

*Urine culture and sensitivity (__/___/___)_____

24-hour urine (___/___/___) ECC_____ TP_____

*Stool Examination with occult blood test (___/___/___)_____

*Throat swab culture and sensitivity (___/___/___)_____

*Chest X-ray (___/___/___)_____

*Whole Abdomen US (__/___/___)_____

_____

*ECG (__/___/___)_____

*2D Echo (___/___/___) EF_____%_____

_____

Sputum c/s (___/___/___)_____

Chest CT scan (___/___/___)_____

_____

EGD (___/___/___)_____

Colonoscopy (___/___/___)_____

Aorto-iliac dupplex ultrasound of arteries and veins, when indicated (___/___/___)_____

Carotid doppler, when indicated (___/___/___)_____

Dobutamine Stress Echo, when indicated (___/___/___)_____

_____

Cardiac scintigraphy (___/___/___)_____

Serology: (___/___/___)

*HBs Ag_____ *Anti-HBc _____ *Anti-HBs _____ HBV-DNA-_____ *Anti-HCV_____HCV-RNA_____

*HIV/HACT_____ *VDRL _____ *CMV IgG titer_____*EBV_____*PSA (for males > 50 yo)_____

Immunology: *PRA Screen (___/___/___) Class I ____% Class II____%

*PRA Specific if PRA Screen Positive, PRA Specific/PRA Single Antigen Bead

(___/___/___) _____

*Tissue Crossmatch (___/___/___) _____

*Blood Type _____ *Tissue Typing ____A_____,_____B_____,_____DR_____,_____ No. of HLA Mismatch _____

Immunization Status ☐ **Hepatitis B (__/__/__)** ☐ **Pneumovax (__/__/__)** ☐ **Flu (__/__/__)**

Clearances **(Indicate the dates and physicians)**

*Pre-transplant Orientation _____ *Ethics Committee, if LNRD _____

_____ _____

*Cardiovascular _____ Pulmonary _____

Infectious _____ Urology/Gyne _____

Dental _____ Others _____

* Mandatory service

Certified correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

PhilHealth Accreditation No. | | | | | | | | | | | | |

Date signed: _____

PRE-TRANSPLANT EVALUATION FORM FOR KIDNEY TRANSPLANT DONOR
Attachment to Tranche 1

Please answer all questions completely and accurately. Tick appropriate boxes.

Name (Last, First, Middle)_____ ☐ NBB ☐ Fixed Co-Pay

Age _____ Sex ☐ Male ☐ Female Civil Status: ☐ Single ☐ Married ☐ Widow ☐ Separated

Race _____ Hospital No. _____

Permanent Address _____

_____ Tel. No. _____

Present Address _____

_____ Tel. No. _____

Name and address of a close relative or a friend who can provide information in case the donor has a change in address: _____

_____ Tel. No. _____

Nephrologist _____ Transplant Surgeon _____

Urologist _____

PhilHealth ID No. ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

PRE-KIDNEY DONATION DATA

Name of Recipient (Last, First, MI) _____

Specific relationship to the recipient

☐ Living Related Donor

☐ parent ☐ sibling ☐ child ☐ first cousin ☐ nephew/niece ☐ aunt/uncle

☐ Living Non-related Donor

State relationship _____

Past Medical and Social History

☐ No Disease ☐ HPN ☐ DM ☐ Asthma ☐ Renal Stone

☐ Previous Surgeries _____

☐ Allergies _____

☐ Smoking _____ pack- years

☐ Alcohol Intake _____ drinks/per day x _____ years

☐ Others, specify _____

Family history

☐ HPN ☐ DM ☐ Renal Disease, specify _____

☐ Others, specify _____

MASTER Date: 11/6/16 Dis:

PRE-KIDNEY DONATION TESTS *(recent laboratory tests and indicate dates)*

Hematology (___/___/___)

*WBC_____*Hgb_____*Hct_____*Platelet_____*Bleeding Time_____*PT_____*PTT_____

Blood Chemistries (___/___/___)

*Crea _____ BUN_____ *FBS _____ *Chole _____ *Trig _____

*SGPT _____*K _____*Na _____ Ca _____ P _____*Uric Acid _____

Others _____

Urine Examination:

* (___/___/___) Sp.Gr._____ pH____ Protein___ Blood___Sugar ___WBC _____RBC_____

* (___/___/___) 24-hour urine TP _____ or Urine Protein Creatinine ratio _____

* (___/___/___) Urine culture and sensitivity _____

Serology:

*HBs Ag	(___/___/___)	☐ Non-reactive	☐ Reactive
Anti-HBc	(___/___/___)	☐ Non-reactive	☐ Reactive
Anti-HBs	(___/___/___)	☐ Non-reactive	☐ Reactive
*Anti-HCV	(___/___/___)	☐ Non-reactive	☐ Reactive
*HIV/HACT	(___/___/___)	☐ Non-reactive	☐ Reactive
*VDRL/TPPA	(___/___/___)	☐ Non-reactive	☐ Reactive
*CMV IgG	(___/___/___)	☐ Negative	☐ Positive
EBV IgG	(___/___/___)	☐ Negative	☐ Positive
Malarial Smear	(___/___/___)	☐ Negative	☐ Positive

Other tests:

Stool Exam with Occult Blood: (___/___/___) _____

* Chest X-ray (___/___/___) _____

* Whole Abdominal US (___/___/___) _____

_____

* ECG (___/___/___) _____

_____

* Nuclear GFR (___/___/___) _____ml/min Normalized GFR _____ml/min

Right_____ml/min _____%, Left_____ml/min _____%

* CT Renal Angiography (___/___/___) _____

_____

* Blood Type _____ *Tissue Typing_____A_____,_____B_____,_____DR_____,_____

No. of HLA Mismatch _____

CLEARANCES *(Indicate the dates and physicians)*

Cardiovascular (___/___/___) _____

Pulmonary (___/___/___) _____

Infectious (___/___/___) _____

Urology (___/___/___) _____

Gynecologic (___/___/___) _____

Others (___/___/___) _____

☐ Pre-transplant Orientation (___/___/___) ☐ Ethics Committee (___/___/___)

MASTER DOCUMENT Date: 11/6/15 DC: _____

* Mandatory service

Certified correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

PhilHealth Accreditation No. | | | | | | | | | | | | |

Date signed: _____

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Case No. _____

Annex "C2 – KT"

LABORATORY MONITORING FOR RECIPIENT AND DONOR FORM
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

Tranche 2

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

Recipient	Dates Performed			
CBC (4x)				
Creatinine (4x)				
FBS (4x)				
Potassium (1x)				
SGPT (1x)				
Lipid profile (1x)				
Therapeutic drug level (2x)				

Donor	
CBC (1x)	
Creatinine (1x)	
Urinalysis (1x)	

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

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IMMUNOSUPPRESSIVE MEDICATIONS
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

Attachment to Tranche 2

Date: _____

Patient's Name _____ Age _____ Sex _____

Date of KT _____

Present Medications

- cyclosporin Brand name: _____	_____ mg in the AM	_____ mg in the PM 25 mg tab 100 mg tab	
- mycophenolate mofetil Brand name: _____	500 mg	_____ tabs	_____ times a day
- mycophenolate sodium Brand name: _____	360 mg	_____ tabs	_____ times a day
- tacrolimus Brand name: _____	1 mg	_____ tabs	_____ times a day
- everolimus Brand name: _____	0.25 mg	_____ tabs	_____ times a day
- sirolimus Brand name: _____	1 mg	_____ tabs	_____ times a day
- prednisone Brand name: _____	_____ mg	_____ tabs	_____ times a day
- azathioprine Brand name: _____	50 mg	_____ tabs	_____ times a day

_____
Attending Physician

_____
License No.

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Case No. _____

Annex "E1 – KT"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-KT)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-KT)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Checklist of Mandatory and Other Services (Annex C1-KT) with the following attachments: a. Pre-Transplant Evaluation Form For Kidney Transplant Recipient b. Pre-Transplant Evaluation Form For Kidney Transplant Donor	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Nephrologist or Transplant Surgeon	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER DOCUMENT Date: 11/16 DC

Case No. _____

Annex "E2 – KT"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-KT)	
3. Completed PhilHealth Claim Form 2	
4. Monitoring For Recipient And Donor Form (Annex C2-KT) with the following attachment: Immunosuppressive medications	
5. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Nephrologist or Transplant Surgeon	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER DOCUMENT Date: 11/6/15 DC: ___

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Case No. _____

Annex "A – CABG"

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

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

PRE-AUTHORIZATION CHECKLIST
Standard Risk Elective Coronary Artery Bypass Graft (CABG) Surgery

Place a check mark (✓)

QUALIFICATIONS	YES
At least 19 years of age	

ATTESTED BY ATTENDING CARDIOLOGIST or CARDIOVASCULAR SURGEON

Place a check mark (✓)

QUALIFICATIONS	YES
1. Stable coronary artery disease requiring ELECTIVE ISOLATED CABG with indication based on coronary anatomy, symptom severity, left ventricular function, and/or viability tests; non-invasive testing completed and discussed with patient	
2. Check current medical status:	
a. NOT in severe decompensated heart failure by New York Functional Classification (NYFC IV)	
b. NOT with severe angina by Canadian Cardiovascular Society (CCS Class IV)	
c. NO other cardiac/vascular procedures/interventions planned to be done with coronary artery bypass graft surgery during this admission	
d. NO history of dialysis and NO current requirement of dialysis	

3. Based on past history: a. NO previous thoracic/cardiac surgery through median sternotomy	
b. NO previous transcutaneous cardiac intervention within 30 days before contemplated schedule of coronary artery bypass graft surgery	
4. ONLINE EUROSCORE II and Society of Thoracic Surgeons (STS) scoring predictive of low mortality risk (< 5%)	

Place a check mark (✓)

DIAGNOSTICS*	YES	DATE DONE (mm/dd/yy)
1. Coronary Angiography: coronary anatomy amenable for CABG and consistent with Class I and IIa indications for CABG surgery and discussed with patient .		
2. Current status of myocardial viability consistent with benefit from CABG and discussed with patient		

*Must be done at least within one fiscal (1) year from date of receipt of pre-authorization checklist and request by the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO).

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No. – –	PhilHealth Accreditation No. – –
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

MASTER DOCUMENT Date: 11/16/16 DC:

Note:
Once approved, the contracted hospital shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the LHIO or PRO 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Standard Risk Elective Coronary Artery Bypass Graft (CABG) Surgery

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 HCI)
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)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) 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)

MASTER DOCUMENT Date: 10/4/17 DC:

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		

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Case No. _____

Annex "C1 – CABG"

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

CHECKLIST OF MANDATORY and OTHER SERVICES
Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)

Tranche 1

Place a ✓ in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
I. Preoperative laboratory tests such as :	
a. CBC	
b. Platelet count	
c. Blood typing	
d. Na	
e. K	
f. Mg	
g. Calcium	
h. FBS	
i. BUN	
j. Creatinine	
k. Chest X-ray (PA/lateral)	
l. 12-lead ECG	
m. Room air arterial blood gas	
n. Protime-INR	
o. Plasma thromboplastin time	
II. Medications (if no contraindications)	
a. Beta blocker OR calcium antagonist	
b. Statin	
c. Ace inhibitor OR ARB	
d. Aspirin OR anti-platelet	
e. Preoperative antibiotic prophylaxis	

Place a ✓ in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
III. Blood bank screening and blood products as indicated	
IV. Open heart surgery under general anesthesia	
V. Immediate postoperative care at surgical ICU	
VI. Continuing postoperative care at regular room	
VII. Cardiac rehabilitation	

Place a ✓ in the status column if DONE or GIVEN, or NA if not applicable.

OTHER SERVICES	Status
1. Additional laboratory tests as needed	
2. Postoperative antibiotics (IV and oral), if indicated	
3. Treatments, as indicated	
a. Incentive spirometry	
b. VTE Prophylaxis	
c. Nebulization with medications such as beta agonist + steroid or salbutamol/pulmonary physiotherapy	
d. Blood glucose monitoring	
e. Wound dressings/wound care	
f. Renal replacement therapy	
4. Other medications, as indicated	
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.	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No. – –	PhilHealth Accreditation No. – –
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Anesthesiologist	(Printed name and signature) Authorized Blood Bank Staff
PhilHealth Accreditation No. – –	PRC License No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Authorized Cardiac Rehabilitation Staff	(Printed name and signature) Patient
PRC License No.	
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Case No. _____

Annex "E1– CABG"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E-CABG)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-CABG)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 OR PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Completed Checklist of Mandatory and Other Services (Annex C-CABG) (Pre-claims Assessment Checklist of Mandatory and Other Services)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Accomplished Surgical Operative Report	
9. Accomplished Anaesthesia Report	
10. Discharge Summary Signed by Attending Physician	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Case No. _____

Annex "E2– CABG"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)

Requirements	**Please Check**
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)	
3. Completed Cardiac Rehabilitation Form	
4. Completed Certificate of OPD Follow-up consultation	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

MASTER Date: 11/6/15

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Case No. _____

Annex "A – TOF"

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

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

PRE-AUTHORIZATION CHECKLIST
Tetralogy of Fallot Surgery

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

	QUALIFICATIONS	YES
1.	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	
2.	Check physical examination: No hepatomegaly or No edema lower extremities	
3.	No congenital chromosomal abnormalities or other congenital defects, except Trisomy 21 (Down's syndrome)	

MASTER COPY DC:

Place a check mark (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yyyy)
Based on the results of 2D Echocardiogram OR, if applicable, cardiac catheterization OR CT angiogram:[2] a. Confirmed Tetralogy of Fallot OR Confirmed Ventricular Septal Defect and pulmonic stenosis, moderate to severe (This is similar to TOF morphology)[3] b. No other associated congenital heart disease (CHD) that includes the following: i. absent pulmonic valve ii. pulmonary valve atresia ii. atrioventricular septal defect (AVSD) c. Confluent and adequate pulmonary artery sizes OR acceptable pulmonary valve annulus d. NO major aorto-pulmonary collateral arteries (MAPCA's)		

[1] Must be done at least within one (1) year from date of application

[2] Attach OFFICIAL 2D ECHO RESULTS in the patient's chart

[3] By morphologic classification of TOF, the components of TOF, which include a VSD with pulmonic stenosis, infundibulovalvar, may be of the same nature as the acyanotic VSD with pulmonic stenosis. The difference lie in the degree of overriding and dilatation of the aorta which is absent in VSD with PS. As such, clinical presentation will be cyanosis in TOF and acyanosis in the pure VSD with PS types. Despite the difference in morphologic components and clinical presentation, the surgical procedure of TOTAL CORRECTION will be the same for both. This includes:

i. VSD Patch Closure
ii. + RVOT repair with or without patch OR
iii. + infundibulectomy of the infundibular muscle

Certified correct by:	Conforme by:
(Printed name and signature) Attending Pediatric Cardiologist	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No.	

Note:

Once approved, the contracted HCI shall print the approved pre-authorization form 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 (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Tetralogy of Fallot Surgery

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 HCI)
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)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Please tick appropriate box ☐ Chair, Department of Pediatric Cardiology ☐ Chief, Division of Pediatric CV Surgery	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:
(Printed name and signature) Patient

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		

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Case No. _____

Annex "C1 – TOF"

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

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

Tranche 1

Place a (✓) in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
1. Preoperative laboratory:	
a. CBC with platelet with blood typing	
b. Chest x-ray (AP-L)	
c. Na, K, Cl, Ca	
d. Creatinine	
e. Protime	
f. Partial thromboplastin time	
2. Pre-operative infective endocarditis (IE) prophylaxis	
a. cefuroxime or other antibiotics as recommended by the health care institution's Infection Control Committee; AND	
b. aminoglycoside (ex. Amikacin)	
3. Procedure done (D3):	
• Repair of Tetralogy of Fallot	
• VSD patch closure	
• With RVOT patch or with infundibulectomy	
4. Intra-operative medicines	
a. Anesthetic medicines: (any of the following)	
• sevoflorane	
• fentanyl	
• midazolam	
• atropine	
• ketamine	
• esmeron	

Place a (✓) in the status column if DONE or GIVEN

MANDATORY SERVICES	Status
b. dexamethasone	
c. calcium gluconate	
d. sodium bicarbonate	
e. potassium chloride	
f. magnesium sulfate	
g. heparin	
h. protamine sulphate	
i. inotropes: (any of the following)	
• dopamine	
• dobutamine	
• nitroglycerine	
• milrinone	
• epinephrine	
5. Intraoperative transesophageal echo or transthoracic echo within 72 hours postop (Attach results in the patient's chart)	
6. Blood transfusion support (as indicated)	
• Fresh whole blood (FWB)	
• Packed red blood cells (pRBC)	
• Fresh frozen plasma (FFP)	
7. Ventilatory support at least 6 hours	
8. Postoperative Laboratory:	
8.1 1st 6 Hours postop	
• CBC with platelet	
• Chest x-ray (portable)	
• PT	
• PTPA	
• Na, K, Ca	
• ABG	
8.2 Postop 5th-7th day (Pre-discharge)	
• CBC	
• Chest x-ray (PAL)	
9. Postoperative medications	
a. inotropes: (any of the following)	
• dopamine	
• dobutamine	
• nitroglycerine drip	
• milrinone	
• epinephrine	
b. calcium gluconate	
c. tramadol OR ketorolac (as indicated)	

Place a (✓) in the status column if DONE or GIVEN

MANDATORY SERVICES	Status
d. sedatives	
• midazolam OR	
• propofol	
e. others (as indicated)	
• antibiotics (based on hospital antibiogram)	
• H2 blocker	
• oral digoxin	
• oral furosemide	
• oral captopril	
• oral paracetamol or ibuprofen	

Certified correct by:	Certified correct by:
(Printed name and signature) Pediatric TCV Surgeon	(Printed name and signature) CV Anesthesiologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Case No. _____

Annex "E1 – TOF"

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

CHECKLIST OR REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)

Tetralogy of Fallot – Elective TOF Repair

Place a check mark (✓)

Requirements	**YES**
1. Transmittal form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1-TOF)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-TOF)	
4. Photocopy of completed ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Signed Checklist of Mandatory and Other Services (Annex C1-TOF)	
7. Photocopy of completed and signed Z Satisfaction Questionnaire (Annex D)	
8. Complete Surgical Operative Report (certified true copy)	
9. Complete Anaesthesia Report (certified true copy)	
10. Intraoperative TEE Report/ Transthoracic within 3days post op (Attach result)	
DATE COMPLETED (mm/dd/yyyy) DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

MASTER DOCUMENT 11/16/15

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Case No. _____

Annex "E2 – TOF"

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

CHECKLIST OR REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Tetralogy of Fallot – Elective TOF Repair

Place a check mark (✓)

Requirements	**YES**
1. Transmittal form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E2-TOF)	
3. Completed Pediatric Cardiac Rehabilitation Form with 4 sessions exercise program	
4. Medical certificate of OPD consultation	
DATE COMPLETED (mm/dd/yyyy) DATE FILED (mm/dd/yyyy)	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Case No. _____

Annex "A1 – VSD"

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

PRE-AUTHORIZATION CHECKLIST
Ventricular Septal Defect (VSD) Closure

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

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yy)
Based on 2D Echocardiogram:[2] a. Confirmed 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 congenital heart disease (CHD) : 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, confirmed by hemodynamic studies, if applicable		

[1] Must be done at least within six (6) months from date of application
[2] Attach OFFICIAL 2D ECHO RESULTS in the patient's chart

MASTER DOCUMENT Date: 11/14/16 DC:

Certified correct by:	Conforme by:
(Printed name and signature) Attending Pediatric Cardiologist	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	

Note:

Once approved, the contracted HCI shall print the approved pre-authorization form 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 (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Ventricular Septal Defect (VSD) Closure

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 HCI)
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)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Please tick appropriate box ☐ Chair, Department of Pediatric Cardiology ☐ Chief, Division of Pediatric CV Surgery	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)
Patient

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER DOCUMENT Date: 11/10/15

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Case No. _____

Annex "A2 – VSD"

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

PRE-AUTHORIZATION CHECKLIST
Ventricular Septal Defect (VSD) Closure with Associated Special Clinical Conditions

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

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yy)
Based on 2D Echocardiogram:[2]		
a. Confirmed 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 congenital heart disease (CHD) : such as coarctation of the aorta		
d. Mild to moderate pulmonic stenosis or aortic insufficiency		
e. Moderate to severe Pulmonary arterial hypertension with reactive pulmonary bed by cardiac catheterization		
f. Down's Syndrome with stable congenital associated defects		

[1] Must be done at least within six (6) months from date of application
[2] Attach OFFICIAL 2D ECHO RESULTS in the patient's chart

MASTER DOCUMENT Date: 11/6/15 DC:

Certified correct by:	Conforme by:
(Printed name and signature) Attending Pediatric Cardiologist	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	

Note:

Once approved, the contracted HCI shall print the approved pre-authorization form 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 (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Ventricular Septal Defect (VSD) Closure with Associated Special Clinical Conditions

DATE OF REQUEST (mm/dd/yyyy)

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (NAME OF HCI) 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)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Please tick appropriate box ☐ Chair, Department of Pediatric Cardiology ☐ Chief, Division of Pediatric CV Surgery	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)
Patient

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER DOCUMENT Date: 11/10/15

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Case No. _____

Annex "C1 – VSD"

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

VENTRICULAR SEPTAL DEFECT
CHECKLIST OF MANDATORY and OTHER SERVICES

Tranche 1

Place a (✓) in the status column if DONE or GIVEN

MANDATORY SERVICES	Status
1. Preoperative laboratory:	
a. CBC with platelet with blood typing	
b. Chest x-ray (AP-L)	
c. Na, K, Cl, Ca	
d. Creatinine	
e. Protime	
f. Partial thromboplastin time	
2. Pre-operative infective endocarditis (IE) prophylaxis	
a. cefuroxime or other antibiotics as recommended by the health care institution's Infection Control Committee; AND	
b. aminoglycoside (ex. amikacin)	
3. Procedure done (D3): VSD Patch Closure	
4. Intra-operative medicines	
a. Anesthetic medicines: (any of the following)	
• sevoflorane	
• fentanyl	
• midazolam	
• atropine	
• ketamine	
• esmeron	

Place a (✓) in the status column if DONE or GIVEN

MANDATORY SERVICES	Status
b. dexamethasone	
c. calcium gluconate	
d. sodium bicarbonate	
e. potassium chloride	
f. magnesium sulfate	
g. heparin	
h. protamine sulphate	
i. inotropes: (any of the following)	
• dopamine	
• dobutamine	
• nitroglycerine	
• milrinone	
• epinephrine	
5. Intraoperative transesophageal echo or transthoracic echo within 72 hours postop (Attach results in the patient's chart)	
6. Blood transfusion support (if applicable)	
• Fresh whole blood (FWB)	
• Packed red blood cells (pRBC)	
• Fresh frozen plasma (FFP)	
7. Ventilatory support at least 6 hours	
8. Postoperative Laboratory:	
8.1 1st 6 Hours postop	
• CBC with platelet	
• Chest x-ray (portable)	
• PT	
• PTPA	
• Na, K, Ca	
• ABG	
8.2 Postop 5th-7th day (Pre-discharge)	
• CBC	
• Chest x-ray (PAL)	
9. Postoperative medications	
a. inotropes: (any of the following)	
• dopamine	
• dobutamine	
• nitroglycerine drip	
• milrinone	
• epinephrine	
b. calcium gluconate	
c. tramadol OR ketorolac (as indicated)	

Place a (✓) in the status column if DONE or GIVEN

MANDATORY SERVICES	Status
d. sedatives	
• midazolam OR	
• propofol	
e. others (if indicated)	
• antibiotics (based on hospital antibiogram)	
• H2 blocker	
• oral digoxin	
• oral furosemide	
• oral captopril	
• oral paracetamol or ibuprofen	

Certified correct by:	Certified correct by:
(Printed name and signature) Pediatric TCV Surgeon	(Printed name and signature) CV Anesthesiologist
PhilHealth Accreditation No. – –	PhilHealth Accreditation No. – –
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. – –	PhilHealth Accreditation No. – –
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Annex "E1 – VSD"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Ventricular Septal Defect – Elective VSD Closure

Place a check mark (✓)

Requirements	YES
1. Transmittal form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1-VSD)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-VSD)	
4. Photocopy of completed ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Signed Checklist of Mandatory and Other Services (Annex C1-VSD)	
7. Photocopy of completed and signed Z Satisfaction Questionnaire (Annex D)	
8. Complete Surgical Operative Report (certified true copy)	
9. Complete Anaesthesia Report (certified true copy)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Annex "E2 – VSD"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Ventricular Septal Defect – Elective VSD Closure

Place a check mark (✓)

Requirements	YES
1. Transmittal form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E2-VSD)	
3. Completed Pediatric Cardiac Rehabilitation Form with 4 sessions exercise program	
4. Medical certificate of OPD consultation	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Documents received by:	Conforme by:
(Printed name and signature) Z Benefits Coordinator	(Printed name and signature) Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Case No. _____

Annex "A – Cervical CA"

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

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

PRE-AUTHORIZATION CHECKLIST
Cervical Cancer

Place a check mark (✓)

QUALIFICATIONS	YES
1. Biopsy result	
2. No previous radiotherapy for cervical cancer	
3. No previous chemotherapy for cervical cancer	
4. Treatment plan	
5. No uncontrolled co-morbid conditions	

Place a check mark (✓)

FIGO Clinical Staging	YES	DATE DONE (mm/dd/yyyy)
Stages: (Choose only one)		
Stage IA1		
Stage IA2		
Stage IB1		
Stage IB2		
Stage IIA1		
Stage IIA2		
Stage IIB		
Stage IIIA		
Stage IIIB		

Certified correct by Attending Gynecologic-Oncologist:

_____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐

Revised as of October 2015

Note: Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) 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 field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Cervical Cancer

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 HCI)
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):

Billing Category: (tick appropriate box)	Treatment modality: (tick appropriate box)
☐ No Balance Billing (NBB) ☐ Co-pay (indicate amount) Php _____	☐ chemoradiation: chemotherapy, cobalt and brachytherapy (low dose) or primary surgery for stage IA1, IA2-IIA1 ☐ chemoradiation: chemotherapy, linear accelerator and brachytherapy (low/high dose)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Gynecologic-Oncologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:
(Printed name and signature) Patient

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	Initial	Date	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			Activity	Initial	Date
Released to HCI:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Case No. _____

Annex "C1.1 – Cervical CA"

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

CHECKLIST OF MANDATORY and OTHER SERVICES
Surgery for Cervical Cancer Stage IA1, IA2-IIA1

Place a (✓) in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
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, as needed	
l. Urinalysis	
m. Histopathology	
n. Imaging:	
n.1. TV-UTZ	
n.2. CT Scan, as needed or MRI, as needed	
o. Blood support, as needed (screening, processing)	
p. Cystoscopy, as needed	
q. Proctosigmoidoscopy, as needed	

Place a (✓) in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
2. Preoperative antibiotic prophylaxis	
3. Procedure done, as needed **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 (Tick appropriate box; choose one) ☐ Bilateral salpingoophorectomy ☐ transposition of ovaries	Date of Procedure : (mm/dd/yyyy) _____
4. Blood Transfusion Support, as needed	
5. Postoperative Laboratory, as needed	
a. CBC with platelet	
b. ECG	
c. Electrolytes	
6. Postoperative Medications (as indicated)	
a. Analgesics	
b. Antibiotics	
c. Hematinics	

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient

MASTER

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Case No. _____

Annex "C1.2 – Cervical CA"

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

CHECKLIST OF MANDATORY and OTHER SERVICES
Chemoradiation with Cobalt and Brachytherapy (Low Dose) for Cervical Cancer

Place a (✓) in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
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, as needed	
l. Urinalysis	
m. Histopathology	
n. Imaging:	
n.1. TV-UTZ	
n.2. CT Scan, as needed or MRI, as needed	
o. Blood support, as needed (screening, processing)	
p. Cystoscopy, as needed	
q. Proctosigmoidoscopy, as needed	

MANDATORY SERVICES	Tick appropriate box
1. Radiation Treatment Summary a. Pelvic cobalt radiation b. Low dose brachytherapy	**Date of Procedure (start mm/dd/yyyy – end mm/dd/yyyy):** _____ **Dates of Procedure (mm/dd/yyyy)** _____ _____ _____ _____

2. Pre chemotherapy laboratory exams per cycle (as indicated)

Cycle	CBC	Creatinine	Mg	Urinalysis
I				
II				
III				
IV				
V				
VI				

3. Chemotherapy medications (Check only one chemotherapy per cycle)

Cycle	Cisplatin	Carboplatin	Others: (specify)	Remarks
I				
II				
III				
IV				
V				
VI				

4. Support medications (as indicated)

Cycle	Anti-emetics	GSF	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				

Place a (✓) in the status column if DONE or GIVEN.

MANDATORY SERVICES	Status
5. Blood Transfusion Support (as indicated)	

6. Post treatment Medications (home medications, as indicated)

Cycle	Anti-emetics	Analgesics	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				

7. Chemotherapy Treatment Summary

Cycle	Date (mm/dd/yyyy)	Remarks
I		
II		
III		
IV		
V		
VI		

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. Date signed (mm/dd/yyyy)

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Case No. _____

Annex "C1.3 – Cervical CA"

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

CHECKLIST OF MANDATORY and OTHER SERVICES
Chemoradiation with Linear Accelerator and Brachytherapy (Low/High Dose) for Cervical Cancer

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY SERVICES	Status
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, as needed	
l. Urinalysis	
m. Histopathology	
n. Imaging:	
n.1. TV-UTZ	
n.2. CT Scan, as needed or MRI, as needed	
o. Blood support, as needed (screening, processing)	
p. Cystoscopy, as needed	
q. Proctosigmoidoscopy, as needed	

MANDATORY SERVICES	Status
1. Radiation Treatment Summary A. Pelvic Radiation ☐ Linear Accelerator B. Brachytherapy ☐ Low dose rate ☐ High dose rate	**Date of Procedure (start mm/dd/yyyy – end mm/dd/yyyy):** _____ **Dates of Procedure (mm/dd/yyyy)** _____ _____ _____ _____

2. Pre chemotherapy laboratory exams per cycle (as indicated)

Cycle	CBC	Creatinine	Mg	Urinalysis
I				
II				
III				
IV				
V				
VI				

3. Chemotherapy Medications (Check only one chemotherapy per cycle)

Cycle	Cisplatin	Carboplatin	Others: (specify)	Remarks
I				
II				
III				
IV				
V				
VI				

4. Support medications (as indicated)

Cycle	Anti-emetics	GSF	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				

Place a (✓) in the status column if DONE or NA if not applicable.

MANDATORY SERVICES	Status
5. Blood Transfusion Support (as indicated)	

6. Post treatment Medications (home medications, as indicated)

Cycle	Anti-emetics	Analgesics	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				

7. Chemotherapy Treatment Summary

Cycle	Date (mm/dd/yyyy)	Remarks
I		
II		
III		
IV		
V		
VI		

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. Date signed (mm/dd/yyyy)

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Case No. _____

Annex "E1.1 – Cervical CA"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Surgery for Cervical Cancer Stage IA1, IA2-IIA1

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1.1-Cervical CA)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Cervical CA)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Checklist of Mandatory and Other Services (Annex C1.1-Cervical CA)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Operative record	
9. 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	
10. Histopathology Result (definitive surgery)	
DATE COMPLETED :	
DATE FILED :	

Certified correct by:	Conforme by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

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Case No. _____

Annex "E1.2 – Cervical CA"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Chemoradiation with Cobalt and Brachytherapy (Low Dose) for Cervical Cancer

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1.2-Cervical CA)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Cervical CA)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Checklist of Mandatory and Other Services (Annex C1.2-Cervical CA)	
7. Photocopy completed Z Satisfaction Questionnaire (Annex D)	
8. 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	
DATE COMPLETED : **DATE FILED :**	

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation Oncologist
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Annex "E1.3 – Cervical CA"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Chemoradiation with Linear Accelerator and Brachytherapy (Low/High Dose) for Cervical Cancer

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1.3-Cervical CA)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Cervical CA)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Checklist of Mandatory and Other Services (Annex C1.3-Cervical CA)	
7. Photocopy completed Z Satisfaction Questionnaire (Annex D)	
8. 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	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Gynecologic Oncologist	(Printed name and signature) Radiation Oncologist
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

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Case No. _____

Annex "A – MORPH"

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

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

PRE-AUTHORIZATION CHECKLIST FOR Z MORPH
Fitting of External Lower Limb Prosthesis below the Knee

Place a check mark (✓) on the appropriate lower limb:
☐Right lower limb ☐Left lower limb ☐Right & left lower limbs

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

	QUALIFICATIONS	Yes
1.	Age at least 15 years	
2.	At least 3 months post-amputation, if acquired	
3.	Wheelchair Independent -Community Ambulator With or without prosthesis	
	With or without cane or crutches or walker	
4.	No Co-morbidities:	
	a. No congestive heart failure or ischemic heart disease	
	b. No chronic obstructive or restrictive lung disease	
	c. No systemic infection	
	d. No mental or behavioral incapacity	
5.	Physical Examination:	
	No fresh or non-healing wound	
	No neuroma or painful residual limb	
	No motor strength <4/5 of lower limbs	
	No limitation of motion of lower limbs	
	No incoordination or poor balance	

MASTER DOCUMENT Date: 11/16/15 DC:

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

_____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐

Note:
Once approved, the contracted hospital shall print the approved pre-authorization form 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 (LHIO) or the PhilHealth Regional Office (PRO) 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 the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST FOR Z MORPH
Fitting of External Lower Limb Prosthesis below the Knee

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)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)
Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCI:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Case No. _____

Annex "E – MORPH"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Fitting of External Lower Limb Prosthesis below the Knee

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E-MORPH)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-MORPH)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Discharge Checklist for Z MORPH (Annex C-MORPH)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)

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Case No. _____

Annex "B – ME Form"

MEMBER EMPOWERMENT FORM
Inform, Support & Empower

Instructions:
1. The health care 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 health care institution (HCI) providing specialized care.
6. Triplicate copies of the ME form shall be made available by the contracted HCI—one for the patient; one as file copy of the contracted HCI providing the specialized care and one for PhilHealth.
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.**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI

A. Member/Patient Information		
PATIENT (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
PERMANENT ADDRESS		
Birthday (mm/dd/yyyy)	Age	Sex
Telephone Number	Mobile Number	Email Address

B. Clinical Information		
1.	Description of condition	
2.	Applicable Treatment Plan agreed upon with healthcare provider	
3.	Applicable alternative Treatment Plan agreed upon with health care provider	

C. Treatment Schedule and Follow-up Visit/s	
1. Date of initial admission to HCI or consult[a] (mm/dd/yyyy) [a]For ZMORPH, this refers to the external lower limb pre-prosthesis rehabilitation consult. For PD First, this refers to 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 admission to HCI or consult[b] (mm/dd/yyyy) [b] For ZMORPH, this refers to the external lower limb measurement, fitting and adjustments For the PD First, this refers to the next visit to the PD Provider.	
3. Date/s of follow-up visit/s[c] (mm/dd/yyyy) [c] For ZMORPH, this refers to the external lower limb post-prosthesis rehabilitation consult.	

D. Member Education		
Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
1. My health care provider explained the nature of my condition.		
2. My health care provider explained the treatment options[d]. [d] For ZMORPH, this refers to the need for pre- and post-external lower limb prosthesis rehabilitation.		
3. The possible side effects/adverse effects of treatment were explained to me.		
4. My health care provider explained the mandatory services and other services required for the treatment of my condition.		
5. I am satisfied with the explanation given to me by my health care provider.		
6. I have been fully informed that I will be cared for by all the pertinent medical specialties, as needed, present in the PhilHealth contracted HCI of my choice and that preferring another contracted HCI for the said specialized care will not affect my treatment in any way.		
7. My health care provider explained the importance of adhering to my treatment plan. This includes completing the course of treatment in the contracted HCI where my treatment was initiated. Note: Non-adherence of the patient to the agreed treatment plan in the HCI may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.		

Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
8. My health care provider gave me the schedule/s of my follow-up visit/s.		
9. My health care provider gave me information where to go for financial and other means of support, when needed. a. Government agency (ex. PCSO, PMS, LGU, etc.) b. Civil society or non-government organization c. Patient Support Group d. Corporate Foundation e. Others (ex. Media, Religious Group, Politician, etc.)		
10. I have been furnished by my health care provider with a list of other contracted HCIs for the specialized care of my condition.		
11. I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits: a. I fulfill all selections criteria for my condition.		
b. The "no balance billing" (NBB) was explained to me. Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.		
c. I understand the NBB policy.		
For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer C.1, C.2 and C.3. c.1. I understand that I can opt out from the NBB and may be charged a fixed copay		
c.2. I opt out from the NBB policy of PhilHealth		
The following are applicable to formal and informal economy, lifetime members and their qualified dependents (d.1 and d.2) d. I understand the fixed copay for members belonging to the formal and informal economy, lifetime members and senior citizens.		
d.1. I understand that as a member belonging to the formal and informal economy, lifetime members, the contracted HCI can charge me a fixed copay.		
d.2. I understand that the fixed copay is for other services needed to treat my condition.		
e. Only five (5) days shall be deducted from the 45 days annual benefit limit for the duration of my treatment under the Z Benefits.		
f. I shall update my premium contributions in order to avail the Z Benefits and other PhilHealth benefits.		

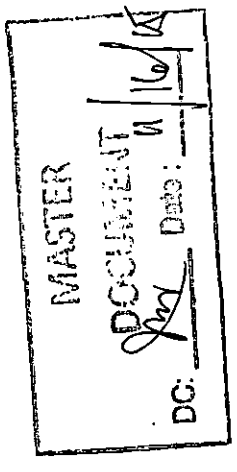
E. Member Roles and Responsibilities		
Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
1. I understand that I am responsible for adhering to my treatment schedule.		
2. I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.		
3. I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.		

F. Printed Name, Signature, Thumb Print and Date		
Printed name and signature of patient* * For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.	Thumb print (if patient is unable to write)	Date (mm/dd/yyyy)
Printed name and signature of Attending Doctor		Date (mm/dd/yyyy)
Witnesses:		
Printed name and signature of HCI staff member		Date (mm/dd/yyyy)
Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative		Date (mm/dd/yyyy)

G. PhilHealth Contact Details		
Name of PhilHealth CARES assigned at the HCI		
Telephone number	Mobile number	Email address

H. Consent to access patient record	I. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)
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 have my medical data entered electronically in the ZBITS as a requirement for the Z Benefits. 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.	

Printed name and signature of patient* * For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.	Thumb print (if patient is unable to write)	Date (mm/dd/yyyy)
Printed name and signature of patient's representative		Date (mm/dd/yyyy)
Relationship of representative to patient (tick appropriate box) ☐ spouse ☐ parent ☐ child ☐ next of kin ☐ guardian		



PhilHealth

Benefits

Annex "D"

Share your opinion with us!

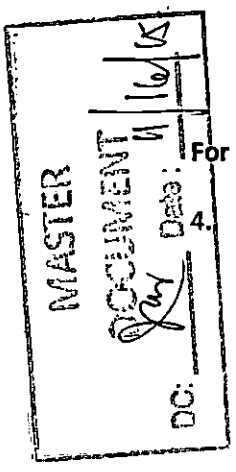
We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health care provider or you may contact PhilHealth call center at 441-7442. 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 transplantation
   - ☐ Cervical cancer
   - ☐ Coronary artery bypass surgery
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for ventricular septal defect
   - ☐ Fitting of external lower limb prosthesis
   - ☐ Orthopedic implants
   - ☐ PD First Z benefits
   - ☐ Colorectal cancer

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 health care institution (HCI) 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 health care 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 HCI 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

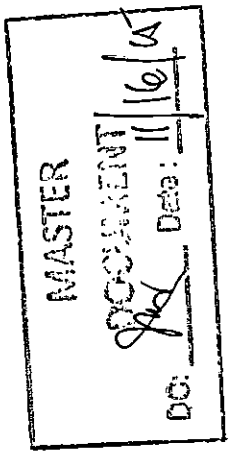
9. If you have other comments, please share them below:

   _____

   _____

   _____

Thank you. Your feedback is important to us!



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Annex "H"

TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

NAME OF CONTRACTED HEALTH CARE INSTITUTION (HCI)	ADDRESS OF HCI

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.
1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Z Benefit Package Code, include the code for the order of tranche payment. Example: breast cancer, second tranche should be written as "Z0022".
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Z Benefit Package Code	Remarks
		Date admitted	Date discharged		
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Certified correct by authorized representative of the HCI		For PhilHealth Use Only	Initials	Date
	Designation	Received by Local Health Insurance Office (LHIO)		
Printed Name and Signature	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

DOCUMENT MASTER Date: 11/16/15

Policy Review Guide for the Z Benefits

Health Finance Policy Sector
Product Team for Special Benefits

I. Introduction

The policy review of the Z Benefits shall be conducted regularly, between one (1) and three (3) years, depending on the nature of the particular policy, i.e. evidence update, rates adjustment, or amendments/revisions to details of the policy. The policy review of each of the Z Benefit Packages is expected to take between one (1) to three (3) months, depending on the scope of new evidence to review, the extent of stakeholders involved and the resources required. The Health Finance Policy Sector shall take the lead in the review process in collaboration with relevant internal and external stakeholders, which shall ensure accuracy of the contents of the policy in order to reflect current needs and practice. The Product Team for Special Benefits shall be the policy contact, which is responsible for developing and reviewing the policy with other policy stakeholders, as well as providing policy advice best suited to answer questions on the application of the policy. PhilHealth and its key stakeholders shall form the policy review team that shall undertake the policy review process.

II. Methodology

A. Knowledge update

The knowledge update is the summary and synthesis of the significant and locally applicable updates in current standards of practice and medical evidence that has taken place since the initial implementation of the Z Benefits policy or since the last policy review. Trained technical staff of the Product Team for Special Benefits shall conduct the systematic search, critical appraisal and syntheses of new evidence relevant to the minimum standards that are pertinent to each of the Z Benefit Packages. Policy research, health technology assessment (HTA), cost-analysis, economic evaluation, and budget impact analysis, among others, shall be conducted as necessary, in collaboration with technical experts, the academe, and key stakeholders. The knowledge update shall be reflected in technical documents and harmonized into the policy of the Z Benefits.

Other areas for consideration in knowledge update are changes or amendments to the Corporation's legal mandate or other applicable statutory rules and regulations to be complied with.

B. Matrix guide for the policy review process

Questions	Yes	No	Action Plan
1. Does the policy achieve its stated purpose?			
a) Are the objectives and expected outcomes stated in the policy achieved since its implementation or last review?			
2. Are the principles stated in the policy still consistent with the Corporation's legal mandate, strategic plans and budget allocation?			
3. Is the policy consistent with the current standards of best practice?			
4. Are there gaps in operations and implementation of the policy? What are the evidence to substantiate these?			
a. Is the policy being complied?			
b. Are the service providers and PhilHealth operations clear about their roles and responsibilities in the implementation of the policy?			
c. What are the barriers to compliance of the policy?			

C. Engaging key stakeholders as members of the policy review team

Relevant stakeholders are the key players who shall use and be affected by the policy. Involvement of these important stakeholders shall improve the quality of the policy and facilitate implementation by getting buy-in from the critical players. They shall be invited to actively participate during the series of engagements and activities for the purpose of the policy review. These stakeholders shall include, but are not limited to, PhilHealth as the policy owner or sponsor, the Department of Health, healthcare providers, content experts, academe, development partners, patient groups, other government institutions, non-government organizations, industry (pharmaceutical, medical devices, suppliers), elected public officials, media, advocacy groups, and the Presidential Management Staff (PMS), among others. Internal stakeholders of PhilHealth shall also be involved in the policy review process. These shall be composed of technical staff representatives from the relevant Sectors and Departments within the Corporation.

D. Building consensus with key stakeholders

The policy review team, in collaboration with the key stakeholders, shall address the policy gaps identified and shall also consider the action plans listed in the matrix guide of the review process. Consensus building shall be conducted in order to arrive at an agreement and resolution for issues raised during the series of activities and engagements in the policy review process. The agreements and resolutions shall be the basis for the proposed amendments, revisions or changes in the policy of the Z Benefits.

E. Seeking management approval of the proposed policy amendments and revisions

After the conduct of stakeholder engagements and policy review activities, agreements and resolutions shall be presented to Management for their approval. Proposed amendments and changes to the current policy that affect package rates, payment schemes, or the overall budget of the Corporation shall be forwarded to the Office of the Actuary for actuarial study. The recommendation/s of the Office of the Actuary shall also be presented to the Management. Decision/s of the Management shall be guided by the policy options and evidence gathered during the policy review process and stakeholder engagements and the recommendation/s of the Actuary.

F. Disseminating the amendments and revisions in the policy

Amendments or revisions to the policy of the Z Benefits shall be disseminated in the proper document, such as circular, office order, memorandum, or advisory. These shall be circulated appropriately to all the concerned PhilHealth Offices, relevant stakeholders, healthcare providers and the public.

Z BENEFIT FOR END STAGE RENAL DISEASE REQUIRING KIDNEY TRANSPLANTATION, LOW-RISK

Table 1. Services included for end-stage renal disease requiring kidney transplantation, low-risk

Mandatory Services (Minimum Standards)	Other Services
Cardiology clearance for recipient	Cardiology clearance for donor, if indicated Hemodialysis or peritoneal dialysis during admission for transplantation, if indicated
Transplantation surgery with living or deceased donor	Graft renal biopsy, if indicated
Immunosuppressant induction therapy, unless identical twin or zero HLA-antigen mismatch	Anti-rejection therapy, if indicated, with methylprednisolone 500 mg IV per day for three (3) days
Immunologic risk-primary kidney transplant, single organ transplant, PRA class 1 and 2 negative or PRA<20%; no donor specific antibody	

Table 2. Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for recipient candidate

Mandatory Services (Minimum Standards)	Other Services
Phase 1 CBC blood typing PT/PTT bleeding Time FBS creatinine urinalysis HBsAg, anti-HBs, anti-HBc CMV IgG anti-HCV HIV TPPA chest x-ray ultrasound of the whole abdomen	Phase 1 HBV-DNA if only anti-HBc+ Chest CT scan
Phase 2 PRA screen PRA specific	
Phase 3 tissue cross-match with living donor HLA tissue typing	
Phase 4 urine C/S sodium calcium potassium phosphorus lipid profile	Phase 4 pregnancy test for female < 45 years old mammogram for female > 40 years old pap smear for women prostate specific antigen for males

Mandatory Services (Minimum Standards)	Other Services
liver function tests uric acid fecalysis with occult blood EBV-IgG ECG 2D echo Throat swab C/S dental evaluation	when indicated: dobutamine stress echo carotid duplex ultrasonography aorto-iliac duplex ultrasound of arteries and veins

Table 3. Pre-transplant evaluation/labs (Phases 1, 2, 3) for donor candidate

Mandatory Services (Minimum Standards)	Other Services
Phase 1 CBC blood typing PT/PTT bleeding Time FBS creatinine urinalysis HBsAg anti-HCV HIV VDRL chest x-ray ultrasound of whole abdomen ECG Phase 2 HLA tissue typing Phase 3 CMV IgG urine C/S sodium calcium potassium phosphorous lipid profile liver function tests uric acid fecalysis with occult blood nuclear GFR renal CT angiogram	Phase 1 2D echo

TABLE 4. IMMUNOSUPPRESSION THERAPY. Choose only one option, either 1, 2, 3 or 4

Mandatory Services (Minimum Standards)	Other Services
Option 1: calcineurin inhibitor + mycophenolate + prednisone with or without induction a. cyclosporine + mycophenolate mofetil or mycophenolate sodium + prednisone OR b. tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone Option 2: calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction a. low-dose cyclosporine + sirolimus + prednisone OR b. low-dose cyclosporine + everolimus + prednisone Option 3: calcineurin inhibitor such as cyclosporine + azathioprine + prednisone with or without induction Option 4: steroid-free for zero HLA-mismatch patient or induction using rabbit antithymocyte globulin	

Table 5. INDUCTION THERAPY. Choose only one option, either 1 or 2

Mandatory Services (Minimum Standards)	Other Services
Option 1: interleukin-2-receptor antibody (basiliximab) 20 mg IV for two (2) doses OR Option 2: lymphocyte depleting agents rabbit anti-thymocyte globulin 1.0-1.5 mg per kg per day for three (3) doses	

Table 6. Laboratory Monitoring for Recipient and Donor

Mandatory Services (Minimum Standards)	Other Services
Recipient CBC (4x) creatinine (4x) FBS (4x) potassium (1x) SGPT (1x) lipid profile (1x) therapeutic drug level (2x) Donor CBC (1x) creatinine (1x) urinalysis (1x)	

Z BENEFIT FOR BREAST CANCER, STAGE 0 TO IIIA

Table 1. Services included for Breast CA cStage 0, Ductal Carcinoma in-situ

Mandatory Services (Minimum Standards)	Other Services
Surgery total mastectomy, OR modified radical mastectomy	CP clearance (if indicated)
Diagnostics mammography histopathology ER/PR	**Diagnostics (if needed)** chest x-ray (PAL) ECG 2D echo CBC (with platelet count) creatinine Her2 neu test FBS protime electrolytes sodium potassium calcium phosphate urinalysis
Adjuvant Therapy If ER(+)PR(+): Tamoxifen* 20 mg OD	

*The contracted HCI shall continue dispensing this drug to the patient, at least for the next five (5) years, unless with contraindications or shifted to other forms of hormonotherapy. The reference price for tamoxifen may be based on the Drug Price Reference Index (DPRI) of the Department of Health-National Center for Pharmaceutical Access and Management (DOH-NCPAM).

Table 2. Services included for Breast Cancer cStage I to IIA

Mandatory Services (Minimum Standards)	Other Services
Surgery modified radical mastectomy	CP clearance (if indicated)
Diagnostics mammography histopathology ER/PR Her2 neu test CBC (with platelet count) ultrasound abdomen chest X-ray	**Diagnostics (if needed)** chest x-ray (PAL) ECG ultrasound of whole abdomen creatinine alkaline phosphatase PT/PTT FBS electrolytes sodium potassium calcium phosphate urinalysis 2D echo SGPT SGOT
Adjuvant Therapy Chemotherapy with: • doxorubicin 60 mg/m^2 + cyclophosphamide 600 mg/ m^2 x 4 cycles OR • For elderly or those with heart disease who cannot tolerate doxorubicin: cyclophosphamide 600mg/m^2 + methotrexate 40mg/m^2 + fluorouracil 600 mg/m^2 x 6 cycles OR • fluorouracil 500 mg/m^2 + doxorubicin 50 mg/m^2 + cyclophosphamide 500 mg/m^2 x 6 cycles Hormonotherapy with: Tamoxifen* 20 mg OD x 5 years	**Other drugs, as needed, which are listed in the latest edition of the Philippine National Formulary (PNF)** anti-emetics antibiotics pain-relievers taxanes (docetaxel, paclitaxel) GCSF **Radiotherapy** Not included in the Z Benefits but as a separate benefit under Case Rates

*The contracted HCI shall continue dispensing this drug to the patient, at least for the next five (5) years, unless with contraindications or shifted to other forms of hormonotherapy. The reference price for tamoxifen may be based on the DPRI of the DOH-NCPAM.

Table 3. Services included for Breast Cancer cStage IIB: T2 N1 M0; T3 (tumor>50mm) N0 M0 to IIIA: T3 N1

Mandatory Services (Minimum Standards)	Other Services
Surgery Modified Radical Mastectomy	CP clearance (if indicated)
Diagnostics mammography histopathology ER/PR Her2 neu test chest x-ray (PAL) ultrasound of whole abdomen CBC (with platelet count) alkaline phosphatase	**Diagnostics (if needed)** ECG creatinine SGOT SGPT calcium 2D echo
Adjuvant Therapy Chemotherapy with: • doxorubicin 60mg/m^2 + cyclophosphamide 600mg/m^2 x 4 cycles → docetaxel 75mg/m^2 x 4 cycles OR • For elderly or those with heart disease who cannot tolerate doxorubicin: cyclophosphamide 600mg/m^2 + methotrexate 40mg/m^2 + fluorouracil 600 mg/m^2 x 6 cycles OR • fluorouracil 500 mg/m^2 + doxorubicin 50 mg/m^2 + cyclophosphamide 500 mg/m^2 x 6 cycles Hormonotherapy with: tamoxifen* 20 mg OD x 5 years	**Other drugs, as needed, which are listed in the latest edition of the Philippine National Formulary (PNF)** anti-emetics antibiotics pain-relievers taxanes (paclitaxel) GCSF **Radiotherapy** Not included in the Z Benefits but as a separate benefit under Case Rates

*The contracted HCI shall continue dispensing this drug to the patient, at least for the next five (5) years, unless with contraindications or shifted to other forms of hormonotherapy. . The reference price for tamoxifen may be based on the DPRI of the DOH-NCPAM.

Z BENEFIT FOR PROSTATE CANCER, LOW TO INTERMEDIATE RISK

Mandatory Services (Minimum Standards)	Other Services
Surgery • laparoscopic prostatectomy OR • radical prostatectomy **CP Clearance** **Prostate Specific Antigen (PSA)**	**Other diagnostic tests, if needed:** chest x-ray ECG abdominal ultrasound core needle biopsy CT scan of pelvis and abdomen bone scan **Other labs, if needed:** creatinine FBS CBC electrolytes urinalysis **Other drugs, as needed, which are listed in the latest edition of the Philippine National Formulary (PNF)** antibiotics pain-relievers anti-androgen drugs **Radiation Therapy, if needed:** Not included in the Z Benefits but as a separate benefit under Case Rates

Z BENEFIT FOR ACUTE LYMPHOCYTIC/LYMPHOBLASTIC LEUKEMIA, STANDARD RISK

Table 1. Services included for Induction Phase

Mandatory Services (Minimum Standards) Induction Phase	**Other Services** Induction Phase
A. Diagnostics 1. bone marrow aspirate examination (morphologic assessment of BMA smears) 2. CSF analysis with WBC differential count 3. CBC (with platelet count) 4. alanine aminotransferase (ALT) 5. bilirubin 6. creatinine 7. PT, PTT 8. serum sodium, potassium, calcium, chloride 9. chest X-ray 10. uric acid	**A. Other diagnostics, as indicated** 1. flow cytometric immunophenotyping 2. CSF cytospin 3. abdominal ultrasound 4. evaluation of infection (ex. blood culture, etc.) 5. cytogenetics 6. BUN 7. Magnesium 8. Phosphorous 9. 2D echocardiography **Blood support and processing** 1. blood typing 2. cross-matching 3. blood screening 4. blood products (ie. packed RBC, platelet concentrate, fresh frozen plasma)
B. Chemotherapy 1. Systemic a) vincristine b) L-asparaginase 2. Intrathecal a) single (methotrexate), OR b) triple (methotrexate, cytarabine, hydrocortisone)	**B. Other Systemic Chemotherapy**, as indicated, such as doxorubicin **C. Other drugs,** as indicated, such as diphenhydramine, prednisone or hydrocortisone **D. Antiemetics,** as indicated, such as ondansetron or metoclopramide **E. Pain medications,** as indicated, such as nalbuphine, tramadol, or paracetamol **F. Anesthetics,** as indicated, such as ketamine, propofol **G. Sedatives** prior to lab procedure, as indicated, such as midazolam, diphenhydramine **H. Antibiotics** that are listed in the latest edition of the Philippine National

Mandatory Services (Minimum Standards) Induction Phase	**Other Services** Induction Phase
	Formulary (PNF), as indicated, such as the following: 1. co-trimoxazole 2. ceftriaxone 3. ceftazidime 4. amikacin 5. other antibiotics based on hospital antibiogram: Specify: _____ _____ _____

Table 2. Services included for Consolidation, Interim Maintenance and Delayed Intensification Phases

Mandatory Services (Minimum Standards) Consolidation, Interim Maintenance and Delayed Intensification Phases	**Other Services** Consolidation, Interim Maintenance and Delayed Intensification Phases
A. Diagnostics 1. CSF Analysis WBC differential count 2. CBC (with platelet count) 3. bilirubin 4. creatinine	**A. Other Diagnostics,** if needed 1. Bone marrow aspirate examination 2. Alanine aminotransferase (ALT) 3. PT/PTT
B. Chemotherapy 1. Systemic a) vincristine b) doxorubicin c) cytarabine d) cyclophosphamide e) methotrexate (IV and oral) f) 6-mercaptopurine 2. Intrathecal a) single (methotrexate), OR b) triple (methotrexate, cytarabine, hydrocortisone)	**B. Chemotherapy** Systemic (i.e. L-asparaginase) **C. Other drugs,** as indicated 1. MESNA 2. dexamethasone 3. hydrocortisone **D. Antiemetics,** as indicated 1. ondansetron 2. metoclopramide **E. Antibiotics** that are listed in the latest edition of the Philippine National Formulary (PNF), as indicated, such as the following: 1. co-trimoxazole 2. ceftriaxone 3. ceftazidime 4. amikacin

Mandatory Services (Minimum Standards) Consolidation, Interim Maintenance and Delayed Intensification Phases	**Other Services** Consolidation, Interim Maintenance and Delayed Intensification Phases
	5. other antibiotics based on hospital antibiogram: Specify: _____ _____ _____

Table 3. Services included for Maintenance Phase

Mandatory Services (Minimum Standards) Maintenance Phase	**Other Services** Maintenance Phase
A. Diagnostics 1. CSF Analysis WBC differential count 2. CBC (with platelet count)	1. Diagnostics, as indicated 2. bone marrow aspirate examination 3. alanine aminotransferase (ALT) 4. creatinine 5. bilirubin 6. amylase 7. cranial CT scan 8. CSF cytospin 9. chest X-ray 10. flow cytometry (to determine minimal residual disease)
B. Chemotherapy 1. Systemic a) vincristine b) methotrexate (oral) c) 6-mercaptopurine 2. Intrathecal a) single (methotrexate), OR b) triple (methotrexate, cytarabine, hydrocortisone)	B. Chemotherapy Systemic (i.e., doxorubicin) C. Other drugs, as indicated 1. dexamethasone 2. prednisone D. Antiemetics, as indicated 1. ondansetron 2. metoclopramide E. **Antibiotics** that are listed in the latest edition of the Philippine National Formulary (PNF), as indicated, such as the following: 1. co-trimoxazole 2. ceftriaxone 3. ceftazidime 4. amikacin 5. other antibiotics based on hospital antibiogram: Specify: _____ _____ _____

Z BENEFIT FOR CORONARY ARTERY BYPASS GRAFT SURGERY

Table 1. Services included for coronary artery bypass graft surgery

Mandatory Services (Minimum Standards)	Other Services
I. Preoperative laboratory tests: a. CBC b. platelet count c. blood typing d. sodium e. potassium f. magnesium g. calcium h. FBS i. BUN j. creatinine k. chest x-ray (PA/lateral) l. 12-lead ECG m. room air arterial blood gas n. protime-INR o. plasma thromboplastin time II. Medications a. beta blocker OR calcium antagonist b. statin c. ACE inhibitor OR ARB d. aspirin OR anti-platelet e. preoperative antibiotic prophylaxis III. Blood bank screening and blood products as indicated IV. Open heart surgery under general anesthesia V. Immediate postoperative care at surgical ICU VI. Continuing postoperative care at regular room VII. Cardiac rehabilitation	1. Additional laboratory tests, if needed: a. CBC b. platelet count c. APTT d. PTPA-INH e. FBS f. sodium g. potassium h. magnesium i. calcium j. BUN k. creatinine l. TPAG m. ABG n. urinalysis o. Others: Specify _____ 2. Additional diagnostic tests, as indicated a. chest x-ray (portable/AP/lateral) b. 12-lead ECG c. 2DED d. TEE 3. Ankle-brachial index, as indicated 4. Carotid duplex scan, as indicated 5. Postoperative antibiotics (IV and oral), if indicated 6. 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

Mandatory Services (Minimum Standards)	Other Services
	7. Other medications, as indicated: a. clopidogrel b. digoxin c. furosemide IV or oral d. amiodarone e. vasopressors i. dopamine ii. norepinephrine iii. epinephrine infusion drip f. inotrope: dobutamine infusion drip g. vasodilators i. NTG ii. isosorbide dinitrate iii. nicardipine h. insulin regimen i. oral hypoglycemic drugs j. proton pump inhibitor/antacid k. pain relievers/analgesics l. Sedatives/anxiolytics m. magnesium chloride n. calcium gluconate o. potassium chloride p. lactulose/stool softeners 8. Pulmonary care, as indicated, such as ventilator support; nebulization, with beta-2 agonist/ combination with steroid 9. Other specialty services if needed, such as pulmonology, nephrology, neurology, infectious diseases, etc.

Z BENEFIT FOR TETRALOGY OF FALLOT

Table 1. Services included for Tetralogy of Fallot

Mandatory Services (Minimum Standards)	Other Services
1. Preoperative laboratory: a. CBC with platelet b. blood typing c. chest x-ray (AP-L) d. Na, K, Cl, Ca e. creatinine f. prothrombin time g. partial thromboplastin time 3. Pre-operative infective endocarditis (IE) prophylaxis a. cefuroxime or other antibiotics as recommended by the health care institution's Infection Control Committee; AND b. aminoglycoside (ex. amikacin) 4. Procedure done (D3): • repair of Tetralogy of Fallot • VSD patch closure • with RVOT patch or with infundibulectomy 5. Intra-operative medicines a. Any of the following anesthetic medicines: • sevoflorane • fentanyl • midazolam • atropine • ketamine • esmeron b. dexamethasone c. calcium gluconate d. sodium bicarbonate e. potassium chloride f. magnesium sulfate g. heparin h. protamine sulphate i. Any of the following inotropes: • dopamine • dobutamine • nitroglycerine • epinephrine	1. Blood transfusion support (if applicable), such as: • fresh whole blood (FWB) • packed red blood cells (pRBC) • fresh frozen plasma (FFP) 2. Other medicines, as indicated • tramadol OR ketorolac • antibiotics (based on hospital antibiogram) • H2 Blocker • oral digoxin • oral furosemide • oral captopril • oral paracetamol or ibuprofen • inotrope (e.g. milrinone)

Mandatory Services (Minimum Standards)	Other Services
6. Intraoperative transesophageal echo or transthoracic echo within 72 hours postop 7. Ventilatory support at least 6 hours 8. Postoperative laboratory tests: a. 1st 6 Hours postop • CBC with platelet • chest x-ray (portable) • PT • PTPA • Na, K, Ca • ABG b. Postop 5th-7th day (Pre-discharge) • CBC • chest x-ray (PAL) 9. Postoperative medications a. Any of the following inotropes: • dopamine • dobutamine • nitroglycerine drip • epinephrine b. calcium gluconate c. sedatives • midazolam OR • propofol	

Z BENEFIT FOR VENTRICULAR SEPTAL DEFECT

Table 1. Services included for Surgery of Ventricular Septal Defect

Mandatory Services (Minimum Standards)	Other Services
1. Preoperative laboratory: a. CBC with platelet b. blood typing c. chest x-ray (AP-L) d. Na, K, Cl, Ca e. creatinine f. prothrombin time g. partial thromboplastin time 2. Pre-operative infective endocarditis (IE) prophylaxis a. cefuroxime or other antibiotics as recommended by the health care institution's Infection Control Committee; AND b. aminoglycoside (ex. amikacin) 3. Procedure done (D3): • VSD patch closure 4. Intra-operative medicines a. Any of the following anesthetic medicines: • sevoflorane • fentanyl • midazolam • atropine • ketamine • esmeron b. dexamethasone c. calcium gluconate d. sodium bicarbonate e. potassium chloride f. magnesium sulfate g. heparin h. protamine sulphate i. Any of the following inotropes: • dopamine • dobutamine • nitroglycerine • epinephrine 5. Intraoperative transesophageal echo or transthoracic echo within 72 hours postop	1. Blood transfusion support (if applicable), such as: • FWB • pRBC • FFP 2. Other medicines, as indicated • tramadol OR ketorolac • antibiotics (based on hospital antibiogram) • H2 Blocker • oral digoxin • oral furosemide • oral captopril • oral paracetamol or ibuprofen • inotrope (e.g. milrinone)

Mandatory Services (Minimum Standards)	Other Services
6. Ventilatory support at least 6 hours 7. Postoperative Laboratory: a. 1st 6 Hours postop • CBC with platelet • chest x-ray (portable) • PT • PTPA • Na, K, Ca • ABG b. Postop 5th-7th day (Pre-discharge) • CBC • chest x-ray (PAL) 8. Postoperative medications a. Any of the following inotropes: • dopamine • dobutamine • nitroglycerine drip • epinephrine b. calcium gluconate c. sedatives • midazolam OR • propofol	

Z BENEFIT FOR CERVICAL CANCER STAGE IA1, IA2-IIA1

Table 1. Services included for Cervical CA, Stage IA1, IA2-IIA1, requiring surgery only

Mandatory Services (Minimum Standards)	Other Services
Surgery (if indicated) **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 OR Transposition of ovaries **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. urinalysis l. histopathology m. imaging: TV-UTZ **Preoperative antibiotic prophylaxis** **Follow up consultation** (within 2 weeks post-procedure)	**Blood Transfusion Support (if indicated)** **Preoperative laboratory (if indicated)** a. partial thromboplastin time b. imaging: CT scan or MRI c. blood support, screening, processing d. cystoscopy e. proctosigmoidoscopy **Postoperative Laboratory (if indicated)** a. CBC with platelet b. ECG c. electrolytes **Postoperative medications (as needed)** a. analgesics b. antibiotics c. hematinics

Table 2. Services included for Cervical CA requiring chemoradiation with cobalt and brachytherapy (low dose)

Mandatory Services (Minimum Standards)	Other Services
Radiation Treatment Summary a. pelvic radiation (pelvic cobalt) b. brachytherapy (low dose) **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. urinalysis l. histopathology m. imaging: TV-UTZ **Chemotherapy medications** a. cisplatin b. carboplatin **Follow up consultation** (within 2 weeks post-procedure)	**Blood Transfusion Support (if indicated)** **Preoperative laboratory (if indicated)** a. partial thromboplastin time b. imaging: CT scan or MRI c. blood support (screening, processing) d. cystoscopy e. proctosigmoidoscopy **Postoperative Laboratory (if indicated)** a. CBC with platelet b. ECG c. electrolytes **Pre-chemotherapy laboratory exams (if indicated)** a. CBC b. creatinine c. magnesium d. urinalysis **Support Medications (if indicated)** a. anti-emetics b. G-CSF c. hematinics **Post treatment medications (home medications, if indicated)** a. anti-emetics b. analgesics c. hematinics

Table 3. Services included for Cervical CA requiring chemoradiation with linear accelerator and brachytherapy (low/high dose)

Mandatory Services (Minimum Standards)	Other Services
Radiation Treatment Summary a. pelvic radiation (linear accelerator) b. brachytherapy (low or high dose rate) **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. urinalysis l. histopathology m. imaging: TV-UTZ **Chemotherapy medications** a. cisplatin b. carboplatin **Follow up consultation** (within 2 weeks post-procedure)	**Blood Transfusion Support (if indicated)** **Preoperative laboratory (if indicated)** a. partial thromboplastin time b. imaging: CT scan or MRI c. blood support, screening, processing d. cystoscopy e. proctosigmoidoscopy **Postoperative Laboratory (if indicated)** a. CBC with platelet b. ECG c. electrolytes **Pre-chemotherapy laboratory exams (if indicated)** a. CBC b. creatinine c. magnesium d. urinalysis **Support Medications (if indicated)** a. anti-emetics b. G-CSF c. hematinics **Post treatment medications (home medications, if indicated)** a. anti-emetics b. analgesics c. hematinics

Z BENEFIT FOR SELECTED ORTHOPEDIC IMPLANTS

Mandatory Services (Minimum Standards)	Other Services
I. Implants for hip arthoplasty a. total hip prosthesis , cemented b. total hip prosthesis , cementless c. partial hip prosthesis, bipolar **II. Implants for hip fixation** multiple screw fixation (MSF) 6.5mm cannulated cancellous screws with washer **III. Implants for pertrochanteric fracture** a. compression hip screw set b. proximal femoral locked plate **IV. Implants for femoral shaft fracture** a. intramedullary nail with interlocking screws b. locked compression plate (LCP) - broad/metaphyseal/ distal femoral LC	

Disclaimer: These mandatory services may be revised as needed based on updated evidence in the medical literature that is acceptable by current standards of practice and applicable in the local setting.

Table 1. Summary of codes for the Z benefits for acute lymphocytic leukemia, standard risk

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Acute lymphocytic/ lymphoblastic leukemia	**Z001**	C91.0, M9821/3	Acute lymphoblastic leukaemia	96408	Chemotherapy administration
				96450	Chemotherapy administration into CNS, requiring and including spinal puncture

Table 2. Summary of codes for the Z benefits for early breast cancer

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Breast cancer	**Z002**	D05.1	Intraductal carcinoma in situ of breast	19180	Mastectomy, simple, complete
		C50	Malignant neoplasm of breast	19240	Mastectomy, modified radical, including axillary lymph nodes, w/ or w/o pectoralis minor muscle, but excluding pectoralis major muscle
				88332	Pathology consultation during surgery; with frozen section(s), two (2) or more blocks
				88331	Pathology consultation during surgery; with frozen section(s), single block
				96408	Chemotherapy administration
				36488	Placement of central venous catheter (subclavian, jugular, or other vein) (e.g., for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous or cutdown

Table 3. Summary of codes for the Z benefits for prostate cancer, low to intermediate risk

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Prostate cancer	**Z003**	C61	Malignant neoplasm of prostate	55810	Prostatectomy, perineal radical;
				55812	w/ lymph node biopsy(s) (limited pelvic lymphadenectomy)
				55815	w/ bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
				55840	Prostatectomy, retropubic radical, w/ or w/o nerve sparing;
				55842	w/ lymph node biopsy(s) (limited pelvic lymphadenectomy)
				55845	w/ bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
				55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing

Table 4. Summary of codes for the Z benefits for kidney transplantation

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Kidney transplantation	**Z004**	N18	Chronic renal failure	50320	Donor nephrectomy, w/ preparation and maintenance of allograft; from living donor
				50340	Recipient nephrectomy
				50360	Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy
				50365	w/ recipient nephrectomy
				50370	Removal of transplanted renal allograft

Table 5. Summary of codes for the Z benefits for coronary artery bypass graft surgery, standard risk

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Elective surgery for coronary artery bypass graft	**Z005**	I20 I25	Angina pectoris Chronic ischaemic heart disease	33510	Coronary artery bypass, vein only; single coronary venous graft
				33511	two coronary venous grafts
				33512	three coronary venous grafts
				33513	four coronary venous grafts
				33514	five coronary venous grafts
				33516	six or more coronary venous grafts
				33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft)
				33518	two venous grafts (list separately in addition to code for arterial graft)
				33519	three venous grafts (list separately in addition to code for arterial graft)
				33521	four venous grafts (list separately in addition to code for arterial graft)
				33522	five venous grafts (list separately in addition to code for arterial graft)

Table 5. Summary of codes for the Z benefits for coronary artery bypass graft surgery, standard risk

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
				33523	six or more venous grafts (list separately in addition to code for arterial graft)
				33533	Coronary artery bypass, using arterial graft(s); single arterial graft
				33534	two coronary arterial grafts
				33535	three coronary arterial grafts
				33536	four or more coronary arterial grafts
				33572	Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjuction w/ coronary artery bypass graft procedure, each vessel (list separately in addition to primary procedure)

Table 6. Summary of codes for the Z benefit for Tetralogy of Fallot

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Surgery for Tetralogy of Fallot	**Z006**	Q21.3	Tetralogy of Fallot Ventricular septal defect with pulmonary stenosis or arterial, dextroposition of aorta and hypertrophy of right ventricle	33684	Closure of ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)
				33692	Complete repair of tetralogy of Fallot w/o pulmonary atresia;
				33694	with transannular patch
				33697	Complete repair of tetralogy of Fallot w/ pulmonary atresia including construction of conduit right ventricle to pulmonary artery and closure of ventricular septal defect
				33684	Closure of ventricular septal defect, with or without patch; with pulmonary valvotomy or infundibular resection (acyanotic)

Table 7. Summary of codes for the Z benefit for ventricular septal defect

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Surgery for ventricular septal defect	**Z007**	Q21	Congenital malformation of cardiac septa	33681	Closure of ventricular septal defect, w/ or w/o patch;

Table 8. Summary of codes for the Z benefit for cervical cancer using chemoradiation with cobalt and brachytherapy (low dose) or primary surgery for stage IA1, IA1-IIA1 as treatment modality

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Cervical cancer: chemoradiation with cobalt and brachytherapy (low dose) or primary surgery for stage IA1, IA1-IIA1	Z008	C53	Malignant neoplasm of vagina	57500	Cervical biopsy
				57520	Cone biopsy
				57522	LEEP
				96408	Chemotherapy
				77401	Radiotherapy, pelvic cobalt
				77761	Brachytherapy (low dose) surface, interstitial or intracavitary
				58150	For Stage IA1 only: Total extra fascial hysterectomy with or without bilateral salpingoophorectomy
				58210	For Stage IA2-IIA1: Radical hysterectomy with bilateral pelvic lymphadenectomy and paraaortic lymph node sampling with or without bilateral salpingoophorectomy

Table 9. Summary of codes for the Z benefit for cervical cancer using chemoradiation with linear accelerator and brachytherapy (low/high dose) as treatment modality

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Cervical cancer: chemoradiation with linear accelerator and brachytherapy (low/high dose)	Z009	C53	Malignant neoplasm of vagina	57500	Cervical biopsy
				57520	Cone biopsy
				57522	LEEP
				96408	Chemotherapy
				77401	Radiotherapy, linear accelerator
				77761	Brachytherapy (low/high dose) surface, interstitial or intracavitary

Table 10. Summary of codes for the fitting of lower limb prosthesis below the knee (ZMORPH)

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
ZMORPH, Right lower limb prosthesis	**Z010-A**	Z44.1			
ZMORPH, Left lower limb prosthesis	**Z010-B**	Z44.1	Fitting and adjustment of artificial leg (complete)(partial)	none	-
ZMORPH, Right and left lower limb prostheses	**Z010-C**	Z44.1			

Table 11. Summary of codes for the Z benefit on selected orthopedic implants

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Total hip prosthesis, cemented	**Z011-A**	none	-	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), w/ or w/o autograft or allograft
Total hip prosthesis, cementless	**Z011-B**	none	-	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip replacement), w/ or w/o autograft or allograft
Partial hip prosthesis, bipolar	**Z011-C**	none	-	27125	Partial hip replacement, prosthesis (e.g., femoral stem prosthesis, bipolar arthroplasty)
Multiple screw fixation 6.5 mm cannulated cancellous screws with washer	**Z011-D**	none	-	27235	Percutaneous skeletal fixation of femoral fracture, proximal end, neck, undisplaced, mildly displaced, or impacted fracture

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Compression hip screw set	**Z011-E**	none	-	27244	Open treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; w/ plate/screw type implant, w/ or w/o cerclage
Proximal femoral locked plate	**Z011-F**	none	-	27244	Open treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; w/ plate/screw type implant, w/ or w/o cerclage
Intramedullary nail with interlocking screws	**Z011-G**	none	-	27506	Open treatment of femoral shaft fracture, w/ or w/o external fixation, w/ insertion of intramedullary implant, w/ or w/o cerclage and/or locking screws
Locked (compression plate broad/ metaphyseal/ distal femoral)	**Z011-H**	none	-	27507	Open treatment of femoral shaft fracture w/ plate/screws, w/ or w/o cerclage

Table 12. Summary of codes for the PD First Z Benefits

Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code	RVS Description
PD First Z Benefits	**Z012**	N18.0	Dialysis procedure other than hemodialysis (e.g. peritoneal, hemofiltration)	90945	End-stage renal disease

Field Monitoring of the Z Benefits

Health Finance Policy Sector
Philippine Health Insurance Corporation

I. Introduction

The Health Finance Policy Sector shall take the lead in the conduct of the field monitoring of the Z Benefits. The conduct of the field monitoring shall be carried out in collaboration with pertinent offices of PhilHealth, PhilHealth Regional Offices and contracted Health Care Institutions (HCIs). It shall be part of the monitoring activities of the Corporation.

The results of the field monitoring shall serve as inputs to the policy review and updates of the Z Benefits as well as one of the bases for evaluating the performance of contracted HCIs in their implementation of the Z Benefits policy.

II. Objectives

The objectives of the field monitoring are:

a. Verify the services received by Z patients from the contracted HCIs;

b. Verify if co-payments were made by sponsored members and the breakdown of co-payments;

c. Determine satisfaction of patients on the services received from the contracted HCIs and the benefits of PhilHealth;

d. Gather personal feedback from actual Z patients which are qualitative data that would serve as inputs to policy research and benefits enhancement.

III. Description of the Field Monitoring

The Field Monitoring is a three-part process.

A. Identification of Z Patients

Z patients are selected from the PhilHealth database for paid claims for tranche 1. These patients are located using the contact details provided to PhilHealth (i.e. telephone numbers, mobile numbers and addresses) that are indicated in their membership data record or their corresponding claim forms. Patients who are not located are excluded from the analysis of the field monitoring. Relatives of patients who expired shall be interviewed to gather pertinent details on the patients.

B. Process of Securing Informed Consent

There are two types of informed consents that shall be administered:

Prior to the conduct of the survey, the first consent (Annex L2) is administered to the patients which informs them or the respondents of the objectives of the field monitoring. This is where they express their willingness to participate in the survey on their own free will. This consent also gives the respondents the right to refuse answering questions they are not comfortable with and the right to withdraw their participation anytime during the interview.

Once the respondent signs the first informed consent, the survey may proceed.

On the other hand, the second informed consent which refers to the patient's consent to publication of information, is secured from the patients or respondents prior to the interview and delivery of patient's testimony. This determines whether they agree to the documentation of the interview through photograph, audio or video coverage (Annex L3). The interviewer explains to the respondents that the documentation shall only be used within proper context in any information campaign of PhilHealth.

Any patient or respondent may opt not to sign the consent to public information.

C. Interview Process

Trained data collectors shall administer the survey questionnaire to the patients at their respective residents, place of work, or any other place that are convenient to the patient or respondent.

The three types of field monitoring tools of the Z benefits are the following:
1. Acute lymphocytic leukemia (Annex L-ALL)
2. Surgery and chemoradiation (Annex L-Surgery, chemotherapy)
3. For surgery only (Annex L-Surgery)

The survey includes questions on satisfaction of the patient on the services received from the contracted HCI and their PhilHealth benefits, the amount of co-payments made and indirect expenses such as the cost of transportation to and from the health facility.

After the interview, patients or respondents are asked to provide other information which they feel are important for the improvement of the Z Benefits.

Apart from the interview, photocopies of the medical charts of Z patients are obtained from the contracted HCIs. Data extraction forms will be used to assure that pertinent information from the medical charts are noted. A sample of the data extraction form for the Z benefits for breast cancer is attached as Annex L4.

Data pertaining to the mandatory services recorded in the medical charts and the interviews are encoded into a database for analysis.

Annex L2

- KOPYA PARA SA PHILHEALTH -

INFORMED CONSENT PARA SA FIELD MONITORING NG MGA PASYENTE NA NAKATANGGAP NG Z BENEFITS NG PHILHEALTH

Isasagawa ang interview na ito para malaman ang kasiyahan ng mga miyembro ng PhilHealth sa serbisyong natanggap nila kaugnay ng Z Benefits.

Ang pakikilahok sa interview na ito ay kusa at maaari ninyo itong bawiin sa anumang oras. Maaari rin ninyong tanggihan ang pagsagot sa mga tanong na hindi kayo kumportableng sagutin. Ang inyong pangalan ay mananatiling confidential at ang impormasyong ibibigay ninyo ay makikita lamang ng mga taong kabilang sa proyekto at kayo bilang isang participant.

Ang mga resulta ng pag-aaral na ito ay makakatulong sa mga program ng PhilHealth, partikular na sa Z Benefits.

ANG INYONG PIRMA AY KATUNAYAN NA SUMASANG-AYON KAYO SA PAMAMARAAN NG GAWAING ITO AT ANG INYONG PAKIKILAHOK AY KUSA NINYONG IBINIBIGAY.

Pangalan _____ **Edad** _____

Pirma _____ **Petsa (mm/dd/yyyy)** _____

✂----------

- KOPYA PARA SA MIYEMBRO -

INFORMED CONSENT PARA SA FIELD VALIDATION NG MGA PASYENTE NA NAKATANGGAP NG Z BENEFITS NG PHILHEALTH

Isasagawa ang interview na ito para malaman ang kasiyahan ng mga miyembro ng PhilHealth sa serbisyong natanggap nila kaugnay ng Z Benefits.

Ang pakikilahok sa interview na ito ay kusa at maaari ninyo itong bawiin sa anumang oras. Maaari rin ninyong tanggihan ang pagsagot sa mga tanong na hindi kayo kumportableng sagutin. Ang inyong pangalan ay mananatiling confidential at ang impormasyong ibibigay ninyo ay makikita lamang ng mga taong kabilang sa proyekto at kayo bilang isang participant.

Ang mga resulta ng pag-aaral na ito ay makakatulong sa mga program ng PhilHealth, partikular na sa Z Benefits.

ANG INYONG PIRMA AY KATUNAYAN NA SUMASANG-AYON KAYO SA PAMAMARAAN NG GAWAING ITO AT ANG INYONG PAKIKILAHOK AY KUSA NINYONG IBINIBIGAY.

Pangalan _____ **Edad** _____

Pirma _____ **Petsa (mm/dd/yyyy)** _____

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

Annex L3

PATIENT CONSENT TO PUBLICATION OF INFORMATION
(based on PhilHealth Office Order 0050 s. 2011)

To be filled out in duplicate. The first copy is submitted to PhilHealth and the second copy remains with the respondent.

Name of person shown in the photograph/video:
Subject Matter: Z BENEFITS
Author of the AVP:

I, _____ (insert full name) give my consent for this information about myself/my child or ward/my relative (circle correct description) relating to the subject matter above to appear in the photograph/video footage in full or in part and in other publications and products published by PhilHealth in the future.

I also allow my/my child or ward/ my relative's image or video footage to be used in PhilHealth's information campaign, as long as the usage is within the proper context.

I understand that I can only revoke my consent at any time before publication, but once the information has been committed to print, it will no longer be possible for me to revoke this consent.

With this consent form, I free PhilHealth from any liabilities that may arise from publication of my/my child or ward/ my relative's image or video footage.

MASTER COPY Date: 11/9/15

Name and signature: _____

Date signed: _____

Relationship to patient (if applicable): _____

If the patient or respondent is unable to write, affix right thumbmark:

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Annex "L-ALL"

Control Number: _____

Z BENEFIT FIELD VALIDATION TOOL FOR ACUTE LYMPHOCYTIC LEUKEMIA

READ BEFORE STARTING THE INTERVIEW:

Magandang umaga/hapon. Una sa lahat, salamat sa pagpapaunlak ninyo sa interview na ito. Ako si _____ *(sabihin ang pangalan)*, naatasang isagawa ang interview sa inyo para malaman ang estado ng serbisyong natanggap ninyo bilang isa sa mga beneficiaries ng Z benefit package at malaman din kung naging sapat ba ang PhilHealth benefit na natanggap ninyo.

Napili kayo bilang respondent sa pamamagitan ng pagpili ng computer sa mga pasyente na naka-avail na ng Z benefit sa mga contracted hospitals. Ayon sa talaan namin, kayo ay na-ospital sa _____ *(sabihin ang pangalan ng ospital)* sa ilalim ng Z benefit noong _____ *(sabihin ang petsa ng pagkaka-ospital)*

Isasagawa natin ang interview na ito sa mahigit kumulang na 20 minutes. Hindi kami hihingi ng kahit anong personal na impormasyon sa inyo maliban lang sa mga mahahalaga para sa Z benefit. Anuman ang inyong sabihin sa interview na ito ay mananatiling confidential at hindi makakaapekto sa membership ninyo sa PhilHealth. Simulan na natin. *(If with recorder, ask permission first).*

1. **Name of Patient (initials):** _____
2. **Province/Municipality:** _____
3. **Educational Attainment:**
   - ☐ none
   - ☐ elementary (undergraduate)
   - ☐ elementary
4. **Age:** _____
5. **Sex:** ☐ male ☐ female

If respondent is not the patient

6. **Name of Respondent:**
   (Last name, first name, middle initial, ext.)
   _____
7. **Relationship to patient:**
   - ☐ parent
   - ☐ sibling
   - ☐ guardian
   - ☐ others: (specify) _____
8. **Educational Attainment:**
   - ☐ none
   - ☐ elementary
   - ☐ high school
   - ☐ vocational
   - ☐ college
   - ☐ post graduate
   - ☐ others: (specify) _____
9. **Age:** _____
10. **Sex:** ☐ male ☐ female

Satisfaction:

11. Kayo ba ay nasiyahan sa serbisyong natanggap ng pasyente mula sa ospital noong siya ay operahan?
☐ hindi ***(proceed to 13)*** ☐ oo

12. Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap niya? ***(proceed to 14)***

_____
_____
_____

13. Kung hindi kayo nasiyahan, anu-anong dahilan? ***(proceed to 14)***

_____
_____
_____

14. Nag chemotherapy ba ng pasyente? ☐ hindi ☐ oo ***(proceed to 16)***

15. Kung *hindi*, ito ba ay ☐ desisyon ng mga magulang
☐ sinabi ng kanyang doktor
☐ may ibang nagpayo; sino? _____

(proceed to 20)

16. Kung *oo*, saan isinagawa ang mga chemotherapy sessions niya? _____
_____

17. Nasiyahan ba kayo sa serbisyong natanggap ng pasyente sa pagkakabigay ng chemotherapy?
☐ hindi ☐ oo ***(proceed to 20)***

18. Kung *hindi* kayo nasiyahan, anu-ano ang dahilan?

_____
_____
_____

PhilHealth Benefit:

19. Nagamit ba ng pasyente ang PhilHealth ng kanyang mga magulang sa kanyang chemotherapy?
☐ hindi ☐ oo

20. Naipaliwanag ba sa inyo ang inyong PhilHealth benefits?
☐ hindi ***(proceed to 22)*** ☐ oo

21. Gaano kalinaw ang pagkakaunawa ninyo sa inyong PhilHealth benefits?
☐ lubos na malinaw
☐ malinaw
☐ di gaanong malinaw
☐ di ko naintindihan

22. Alam niyo ba kung magkano ang bill ninyo sa ospital? ☐ hindi ***(proceed to 24)*** ☐ oo

23. Kung *oo*, magkano ang kabuuang bill ninyo sa ospital? _____

24. Noong nag-chemotherapy ang pasyente,

a. may ipinabili ba sa inyong gamot sa labas ng ospital? ☐ wala ☐ mayroon ☐ NA

b. may ipinabili bang gamit sa inyo sa labas ng ospital? (halimbawa: bulak, gasa, alcohol) ☐ wala ☐ mayroon ☐ NA

c. may ipinagawang lab test ba sa inyo sa labas ng ospital? ☐ wala ☐ mayroon ☐ NA

25. May binayaran ba kayong professional fee ng doktor? ☐ wala ☐ mayroon

26. May mga binayaran pa ba kayong iba bukod sa mga nabanggit sa itaas?
☐ wala ☐ mayroon, anu-ano ang mga ito? _____

_____

_____

27. Naitago ba ninyo ang mga resibo ng inyong binili o kaya ay may kopya ba kayo ng resibo para sa mga binayaran? ☐ wala ***proceed to 31*** ☐ mayroon ☐ NA ***proceed to 31***

28. Kung mayroon kayong naitagong mga resibo ng inyong pinagbayaran, maaari bang makita ang mga ito? ☐ hindi ***proceed to 31*** ☐ oo ☐ NA ***proceed to 31***

29. Kung oo, maaari bang humingi ng pahintulot na ilista ang mga ito?
☐ hindi ***proceed to 31*** ☐ oo ☐ NA ***proceed to 31***

Kung *oo,* ilista ang mga detalye sa ibaba.

30. a. **Medicines:**

Generic name	No. of units	Unit cost	Total cost

b. **Supplies:**

Item	No. of units	Unit cost	Total cost

c. **Diagnostics/ laboratory exams:**

Diagnostics/lab exams	No. of times	Unit cost	Total

d. **Professional Fees:**

Initials	Specialty	Amount

31. Ano ang gamit ninyong sasakyan papunta ng:

Ospital

☐ public , specify _____
☐ private specify _____
☐ sariling sasakyan
☐ nirerentahan
☐ naglakad lang

32. Maaari niyo bang isalarawan ang inyong kabuuang kasiyahan sa mga serbisyo at benepisyong inyong natanggap mula sa ospital at sa PhilHealth? *(Markahan ng ✓)*

☐ Lubos na nasiyahan

☐ Nasiyahan

☐ Di gaanong nasiyahan

☐ Di nasiyahan

33. May nais ba kayong imungkahi para mapabuti pa ang benepisyo ng mga miyembro ng PhilHealth?

_____
_____
_____
_____

Interviewer: _____
Documenter: _____
Photographer/Videographer: _____
Team Leader: _____

Date of Interview (mm/dd/yyyy):
_____
Time of Interview:
_____

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Annex "L-Surgery"

Control Number: _____

Z BENEFIT FIELD VALIDATION TOOL FOR:

- ☐ Kidney transplantation
- ☐ Prostate cancer
- ☐ Coronary artery bypass graft
- ☐ Selected orthopedic implants
- ☐ Ventricular septal defect
- ☐ Tetralogy of Fallot

READ BEFORE STARTING THE INTERVIEW:
Magandang umaga/hapon. Una sa lahat, salamat sa pagpapaunlak ninyo sa interview na ito. Ako si _____ *(sabihin ang pangalan)*, naatasang isagawa ang interview sa inyo para malaman ang estado ng serbisyong natanggap ninyo bilang isa sa mga beneficiaries ng Z benefit package at malaman din kung naging sapat ba ang PhilHealth benefit na natanggap ninyo.

Napili kayo bilang respondent sa pamamagitan ng pagpili ng computer sa mga pasyente na naka-avail na ng Z benefit sa mga contracted hospitals. Ayon sa talaan namin, kayo ay na-ospital sa _____ *(sabihin ang pangalan ng ospital)* sa ilalim ng Z benefit noong _____ *(sabihin ang petsa ng pagkaka-ospital)*

Isasagawa natin ang interview na ito sa mahigit kumulang na 20 minutes. Hindi kami hihingi ng kahit anong personal na impormasyon sa inyo maliban lang sa mga mahahalaga para sa Z benefit. Anuman ang inyong sabihin sa interview na ito ay mananatiling confidential at hindi makakaapekto sa membership ninyo sa PhilHealth. Simulan na natin. *(If with recorder, ask permission first).*

1. **Name of Patient (Initials):** _____
2. **Province/Municipality:** _____
3. **Educational Attainment:**
   - ☐ none
   - ☐ elementary
   - ☐ high school
   - ☐ vocational
   - ☐ college
   - ☐ post graduate
   - ☐ others: (specify) _____
4. **Age:** _____
5. **Sex:** ☐ male ☐ female

If respondent is not the patient

6. **Name of Respondent:**
   (Last name, first name, middle initial, ext.)
   _____
7. **Relationship to patient:**
   - ☐ spouse
   - ☐ parent
   - ☐ child
   - ☐ sibling
   - ☐ guardian
   - ☐ others: (specify) _____

8. **Educational Attainment:**
   - ☐ none
   - ☐ elementary
   - ☐ high school
   - ☐ vocational
   - ☐ college
   - ☐ post graduate
   - ☐ others: (specify) _____

9. **Age:** _____

10. **Sex:** ☐ male ☐ female

11. **PhilHealth membership status of patient:** ☐ member ☐ dependent

12. **Marital status of the patient:**
   - ☐ single
   - ☐ legally married
   - ☐ not legally married
   - ☐ widow/ widower

Employment status:

13. Kayo ba ay isang empleyado: ☐ hindi ☐ oo ***(proceed to 15)***

14. Kung hindi, kayo ba ay:
   - ☐ pensioner
   - ☐ may sariling negosyo
   - ☐ may natatanggap na regular na suporta mula sa pamilya o kamag-anak
   - ☐ iba pa: _____

Satisfaction:

15. Kayo ba ay nasiyahan sa serbisyong natanggap ninyo mula sa ospital noong kayo ay operahan?
   ☐ hindi ***(proceed to 17)*** ☐ oo

16. Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap? ***(proceed to 18)***

_____
_____
_____

17. Kung hindi kayo nasiyahan, anu-anong dahilan? ***(proceed to 18)***

_____
_____
_____

PhilHealth Benefit:

18. Nagamit niyo ba ng inyong PhilHealth sa inyong operasyon? ☐ hindi ☐ oo

19. Naipaliwanag ba sa inyo ang inyong PhilHealth benefits?
   ☐ hindi ***(proceed to 21)*** ☐ oo

20. Gaano kalinaw ang pagkakaunawa ninyo sa inyong PhilHealth benefits?
   - ☐ lubos na malinaw
   - ☐ malinaw
   - ☐ di gaanong malinaw
   - ☐ di ko naintindihan

21. Alam niyo ba kung magkano ang bill ninyo sa ospital? ☐ hindi ***(proceed to 23)*** ☐ oo

22. Kung *oo*, magkano ang kabuuang bill ninyo sa ospital? _____

23. Habang kayo ay naka-admit,

a. may ipinabili ba sa inyong gamot sa labas ng ospital? ☐ wala ☐ mayroon

b. may ipinabili bang gamit sa inyo sa labas ng ospital? (halimbawa: bulak, gasa, alcohol) ☐ wala ☐ mayroon

c. may ipinagawang lab test ba sa inyo sa labas ng ospital? ☐ wala ☐ mayroon

24. May binayaran ba kayong professional fee ng doctor? ☐ wala ☐ mayroon

25. May mga binayaran pa ba kayong iba bukod sa mga nabanggit sa itaas?
☐ wala ☐ mayroon, anu-ano ang mga ito? _____
_____
_____

26. Naitago ba ninyo ng mga resibo ng inyong binili o kaya ay may kopya ba kayo ng resibo para sa mga binayaran? ☐ wala ***proceed to 30*** ☐ mayroon ☐ NA ***proceed to 30***

27. Kung mayroon kayong naitagong mga resibo ng inyong pinagbayaran, maaari bang makita ang mga ito? ☐ hindi ***proceed to 30*** ☐ oo ☐ NA ***proceed to 30***

28. Kung oo, maaari bang humingi ng pahintulot na ilista ang mga ito?
☐ hindi ***proceed to 30*** ☐ oo ☐ NA ***proceed to 30***

Kung *oo*, ilista ang mga detalye sa ibaba.

29. a. **Medicines:**

Generic name	No. of units	Unit cost	Total cost

b. **Supplies:**

Item	No. of units	Unit cost	Total cost

c. **Diagnostics/ laboratory exams:**

Diagnostics/lab exams	No. of times	Unit cost	Total

d. **Professional Fees:**

Initials	Specialty	Amount

30. Ano ang gamit ninyong sasakyan papunta ng:

Ospital

- ☐ public , specify _____
- ☐ private specify _____
  - ☐ sariling sasakyan
  - ☐ nirerentahan
- ☐ naglakad lang

31. Maaari niyo bang isalarawan ang inyong kabuuang kasiyahan sa serbisyong inyong natanggap? *(Markahan ng ✓)*

☐ Lubos na nasiyahan

☐ Nasiyahan

☐ Di gaanong nasiyahan

☐ Di nasiyahan

32. May nais ba kayong imungkahi para mapabuti pa ang benepisyo ng mga miyembro ng PhilHealth?

_____
_____
_____
_____
_____

Interviewer: _____
Documenter: _____
Photographer/Videographer: _____
Team Leader: _____

Date of Interview (mm/dd/yyyy): _____

Time of Interview: _____

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Annex "L-Surgery, Chemotherapy"

Control Number: _____

Z BENEFIT FIELD VALIDATION TOOL FOR:

READ BEFORE STARTING THE INTERVIEW:

Magandang umaga/hapon. Una sa lahat, salamat sa pagpapaunlak ninyo sa interview na ito. Ako si _____ *(sabihin ang pangalan)*, naatasang isagawa ang interview sa inyo para malaman ang estado ng serbisyong natanggap ninyo bilang isa sa mga beneficiaries ng Z benefit package at malaman din kung naging sapat ba ang PhilHealth benefit na natanggap ninyo.

Napili kayo bilang respondent sa pamamagitan ng pagpili ng computer sa mga pasyente na naka-avail na ng Z benefit sa mga contracted hospitals. Ayon sa talaan namin, kayo ay na-ospital sa _____ *(sabihin ang pangalan ng ospital)* sa ilalim ng Z benefit noong _____ *(sabihin ang petsa ng pagkaka-ospital)*

Isasagawa natin ang interview na ito sa mahigit kumulang na 20 minutes. Hindi kami hihingi ng kahit anong personal na impormasyon sa inyo maliban lang sa mga mahahalaga para sa Z benefit. Anuman ang inyong sabihin sa interview na ito ay mananatiling confidential at hindi makakaapekto sa membership ninyo sa PhilHealth. Simulan na natin. *(If with recorder, ask permission first).*

1. **Name of Patient (initials):** _____
2. **Province/Municipality:** _____
3. **Educational Attainment:**
   - ☐ none
   - ☐ elementary
   - ☐ high school
   - ☐ vocational
   - ☐ college
   - ☐ post graduate
   - ☐ others: (specify) _____
4. **Age:** _____
5. **Sex:** ☐ male ☐ female

If respondent is not the patient

6. **Name of Respondent:**
   (Last name, first name, middle initial, ext.)
   _____
7. **Relationship to patient:**
   - ☐ spouse
   - ☐ parent
   - ☐ child
   - ☐ sibling
   - ☐ guardian
   - ☐ others: (specify) _____
8. **Educational Attainment:**
   - ☐ none
   - ☐ elementary
   - ☐ high school
9. **Age:** _____
10. **Sex:** ☐ male ☐ female

☐ vocational
☐ college
☐ post graduate
☐ others: (specify) _____

11. PhilHealth membership status of patient: ☐ member ☐ dependent

12. Marital status of the patient:
☐ single
☐ legally married
☐ not legally married
☐ widow/ widower

Employment status:

13. Kayo ba ay isang empleyado: ☐ hindi ☐ oo ***(proceed to 15)***

14. Kung hindi, kayo ba ay:
☐ pensioner
☐ may sariling negosyo
☐ may natatanggap na regular na suporta mula sa pamilya o kamag-anak
☐ iba pa: _____

Satisfaction:

15. Kayo ba ay nasiyahan sa serbisyong natanggap ninyo mula sa ospital noong kayo ay operahan?
☐ hindi ***(proceed to 17)*** ☐ oo

16. Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap? ***(proceed to 18)***
_____
_____
_____

17. Kung hindi kayo nasiyahan, anu-anong dahilan? ***(proceed to 18)***
_____
_____
_____

18. Kayo ba ay nag chemotherapy? ☐ hindi ☐ oo ***(proceed to 20)***

19. Kung *hindi*, ito ba ay
☐ sarili ninyong desisyon
☐ sinabi ng inyong doctor
☐ may ibang nagpayo; sino? _____
(proceed to 23)

20. Kung *oo*, saan isinagawa ang mga chemotherapy sessions ninyo? _____
_____

21. Nasiyahan ba kayo sa serbisyong natanggap ninyo sa pagkakabigay ng chemotherapy?
☐ hindi ☐ oo ***(proceed to 23)***

22. Kung *hindi* kayo nasiyahan, anu-ano ang dahilan?
_____
_____
_____

MASTER
DOCUMENT
Date: 11/16
DC: ___

PhilHealth Benefit:

23. Nagamit niyo ba ng inyong PhilHealth sa inyong operasyon? ☐ hindi ☐ oo

24. Nagamit niyo ba ng inyong PhilHealth sa inyong chemotherapy? ☐ hindi ☐ oo ☐ NA

25. Naipaliwanag ba sa inyo ang inyong PhilHealth benefits?
☐ hindi ***(proceed to 27)*** ☐ oo

26. Gaano kalinaw ang pagkakaunawa ninyo sa inyong PhilHealth benefits?
☐ lubos na malinaw
☐ malinaw
☐ di gaanong malinaw
☐ di ko naintindihan

27. Alam niyo ba kung magkano ang bill ninyo sa ospital? ☐ hindi ***(proceed to 29)*** ☐ oo

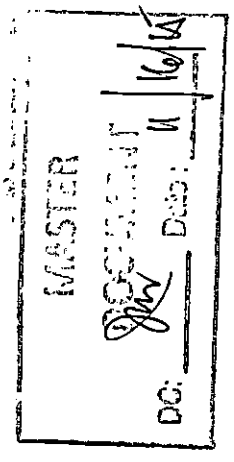
28. Kung *oo*, magkano ang kabuuang bill ninyo sa ospital? _____

29. Habang kayo ay naka-admit,
    a. may ipinabili ba sa inyong gamot sa labas ng ospital? ☐ wala ☐ mayroon
    b. may ipinabili bang gamit sa inyo sa labas ng ospital? (halimbawa: bulak, gasa, alcohol) ☐ wala ☐ mayroon
    c. may ipinagawang lab test ba sa inyo sa labas ng ospital? ☐ wala ☐ mayroon

30. Noong kayo ay nag-chemotherapy,
    a. may ipinabili ba sa inyong gamot sa labas ng ospital? ☐ wala ☐ mayroon ☐ NA
    b. may ipinabili bang gamit sa inyo sa labas ng ospital? (halimbawa: bulak, gasa, alcohol) ☐ wala ☐ mayroon ☐ NA
    c. may ipinagawang lab test ba sa inyo sa labas ng ospital? ☐ wala ☐ mayroon ☐ NA

31. May binayaran ba kayong professional fee ng doctor? ☐ wala ☐ mayroon

32. May mga binayaran pa ba kayong iba bukod sa mga nabanggit sa itaas?
☐ wala ☐ mayroon, anu-ano ang mga ito? _____
_____
_____



33. Naitago ba ninyo ng mga resibo ng inyong binili o kaya ay may kopya ba kayo ng resibo para sa mga binayaran? ☐ wala ***proceed to 37*** ☐ mayroon ☐ NA ***proceed to 37***

34. Kung mayroon kayong naitagong mga resibo ng inyong pinagbayaran, maaari bang makita ang mga ito? ☐ hindi ***proceed to 37*** ☐ oo ☐ NA ***proceed to 37***

35. Kung oo, maaari bang humingi ng pahintulot na ilista ang mga ito?
☐ hindi ***proceed to 37*** ☐ oo ☐ NA ***proceed to 37***

Kung *oo,* ilista ang mga detalye sa ibaba.

36. a. **Medicines:**

Generic name	No. of units	Unit cost	Total cost

b. **Supplies:**

Item	No. of units	Unit cost	Total cost

c. **Diagnostics/ laboratory exams:**

Diagnostics/lab exams	No. of times	Unit cost	Total

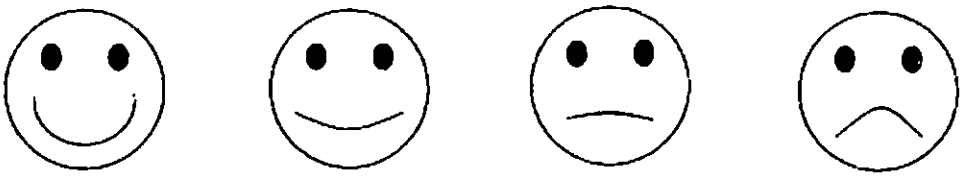
d. **Professional Fees:**

Initials	Specialty	Amount

37. Ano ang gamit ninyong sasakyan papunta ng:

a. Ospital	☐ public , specify _____ ☐ private specify _____ ☐ sariling sasakyan ☐ nirerentahan ☐ naglakad lang
b. pasilidad ng chemotherapy	☐ public , specify _____ ☐ private specify _____ ☐ sariling sasakyan ☐ nirerentahan ☐ naglakad lang

1. Maaari niyo bang isalarawan ang inyong kabuuang kasiyahan sa mga serbisyo at benepisyong inyong natanggap mula sa ospital at sa PhilHealth? *(Markahan ng ✓)*



☐ Lubos na nasiyahan ☐ Nasiyahan ☐ Di gaanong nasiyahan ☐ Di nasiyahan

2. May nais ba kayong imungkahi para mapabuti pa ang benepisyo ng mga miyembro ng PhilHealth?

_____
_____
_____
_____

Interviewer: _____
Documenter: _____
Photographer/Videographer: _____
Team Leader: _____

Date of Interview (mm/dd/yyyy):
_____
Time of Interview:
_____

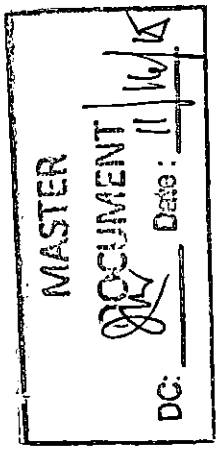


Table 1. Summary of age requirements in the selections criteria for the Z Benefits

Z Benefit Package	Age Requirements[a]
1. Acute Lymphocytic Leukemia	1 to 10[b] years and 364 days
2. Breast cancer	None
3. Prostate cancer	At least 40[c] years of age
4. Kidney Transplantation	At least 10[b] years of age
5. Coronary artery bypass graft	At least 19[d] years of age
6. Ventricular septal defect	1 to 10[d] years and 364 days
7. Tetralogy of Fallot	1 to 10[d] years and 364 days
8. Cervical cancer	None
9. Z MORPH	At least 15[e] years of age
10. Selected orthopedic implants:	
a. Total Hip Prosthesis, cemented	At least 66[f] years of age
b. Total Hip Prosthesis, cementless	65 years and 364[f] days and below
c. Partial Hip Prosthesis bipolar	None
d. Multiple screw fixation (MSF) 6.5mm cannulated cancellous screws with washer	59 years and 364[f] days old and below (both displaced and undisplaced fracture); 60[f] years old and above (undisplaced fracture)
e. Compression hip screw set	None
f. Proximal femoral locked plate	None
g. Intramedullary Nail with Interlocking Screws	None
h. Locked Compression Plate	None
11. Peritoneal dialysis Z Benefit	At least 10[c] years of age

[a] Set by clinical experts from reference hospitals as of 2014
[b] Set by Reference HCI: Philippine Children's Medical Center
[c] Set by Reference HCI: National Kidney and Transplant Institute
[d] Set by Reference HCI: Philippine Heart Center
[e] Set by Reference HCI: University of the East Ramon Magsaysay Memorial Medical Center
[f] Set by Reference HCI: Philippine Orthopedic Center

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Annex "O – Breast Cancer Medical Records Summary"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
PATIENT (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
Date of Approval of Pre-authorization (mm/dd/yyyy)	Date of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)

BREAST CANCER MEDICAL RECORDS SUMMARY FORM

Instructions: This form is required for all breast cancer mortalities and "lost to follow-up[1]" patients in contracted health care institutions. Completely fill-out all required items. Submit this form as attachment to claims for the 2nd tranche.

I. Breast Cancer Disease Profile

Laterality of breast cancer (Choose one by ticking the appropriate box)	☐ Right
	☐ Left
	☐ Both
	☐ Not recorded in the chart
Biopsy Histological Diagnosis (Verbatim from histopathology report)	
Date of biopsy	Date (mm/dd/yyyy)
Clinical Cancer Stage at pre-authorization (Choose one by ticking the appropriate box)	☐ CIS
	☐ I
	☐ IIA
	☐ IIB
	☐ IIIA
	☐ Not recorded in the chart

TNM (Choose one by ticking the appropriate box)	☐ With data
	☐ Not recorded in the chart
If with data on TNM:	What is T?
	What is N?
	What is M?
Widest diameter size of primary tumor	__ __.__ (cm) or __ __ (mm)
	☐ Not recorded in the chart
Skin ulceration (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ Not recorded in the chart
Skin satellite lesion/s (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ Not recorded in the chart
Multifocal carcinomata (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ Not recorded in the chart
Regional lymph node involvement (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ Not recorded in the chart
Distant metastasis (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ Not recorded in the chart
If yes, when did first metastasis happen?	☐ Date (mm/dd/yyyy)
	☐ Not recorded in the chart
If yes, which organ site/s? (Can choose more than one by checking the appropriate box/es)	☐ Regional lymph nodes
	☐ Brain
	☐ Skin
	☐ Lung
	☐ Pleura
	☐ Liver
	☐ Adrenal
	☐ Bone
	☐ Peritoneum
	☐ Pelvic
	☐ Adjacent Organ/s (Specify):
	☐ Others (Specify):
Post-surgical histological diagnosis (Verbatim from pathological report)	

Date of post-surgical histopathologic report	(mm/dd/yyyy)
Histological/nuclear grade (Choose one by checking the appropriate box)	☐ GX: Grade cannot be assessed (undetermined grade)
	☐ G1: well-differentiated (low grade)
	☐ G2: moderately differentiated (intermediate grade
	☐ G3: poorly differentiated (high grade)
	☐ G4: undifferentiated (high grade)
	☐ Not recorded in the chart
Pathological Cancer Stage (Choose one by checking the appropriate box)	☐ CIS
	☐ I
	☐ IIA
	☐ IIB
	☐ IIIA
	☐ IIIB
	☐ IV
	☐ Not recorded in the chart
Provide the appropriate information for TNM	What is T?
	What is N?
	What is M?
	☐ Not recorded in the chart
Widest diameter of primary tumor	__ __.__ (cm) or __ __ (mm)
	☐ Not recorded in the chart
Number of positive lymph nodes/TLNs harvested	__ __ positive lymph nodes __ __ TLNs
	☐ Not recorded in the chart
Lymphovascular invasion (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Not recorded in the chart
Perineural invasion (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Not recorded in the chart
Surgical margin involvement (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Not recorded in the chart
Were tumor markers done? (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ Not recorded in the chart
ER (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive: ___% (1% to 100%); Alfred score ____
	☐ Not recorded in the chart
PR (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive: ___% (1% to 100%); Alfred score ____
	☐ Not recorded in the chart

Her2neu IHC staining intensity (Choose one by checking the appropriate box)	☐ Negative
	☐ Positive
	☐ Equivocal
	☐ Not recorded in the chart
Her2neu gene amplification (Choose one by checking the appropriate box)	☐ Non-amplified
	☐ Amplified
	☐ Not recorded in the chart

II. Breast Cancer Treatment Profile

Was definitive surgery done? (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ No operative record in the chart
If yes, what is the name of the surgical procedure?	
Was chemotherapy given in the contracted health care institution? (Choose one by checking the appropriate box)	☐ Yes
	☐ No
	☐ No record found in the contracted health care institution
	☐ Chemotherapy was given by another healthcare provider
If answer to previous question is "no," check the appropriate box and must provide details.	☐ Patient preference ☐ Advised by healthcare provider ☐ Patient is "lost to follow-up[1]"
If answer is "yes," specify the drug regimen used.	
Specify the total dose per cycle for the drug regimen used (Choose one by checking the appropriate box)	☐ Total dose per cycle: _____ ☐ Not recorded in the chart
If chemotherapy was given, provide the date when chemotherapy started (Choose one by checking the appropriate box)	☐ mm/dd/yyyy _____ ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
If chemotherapy was given, how many cycles were given? (Choose one by checking the appropriate box)	☐ _____ ☐ NA, chemotherapy was not given

[1] Lost to follow-up means the patient has not come back as advised for immediate next treatment visit or within 12 weeks from last patient-attended clinic visit. Visiting the clinic for a treatment more than 12 weeks from advised scheduled treatment visit renders the patient lost to follow-up. The contracted healthcare institution is required to submit a sworn declaration for all their breast cancer patients who are "lost to follow-up."

What is the purpose of chemotherapy? (Choose one by checking the appropriate box)	☐ Adjuvant ☐ Neo-adjuvant ☐ NA, chemotherapy was not given
What is tumor response to chemotherapy? (Choose one by checking the appropriate box)	☐ NED (no evidence of disease progression) ☐ CR ☐ PR ☐ SD ☐ PD (progressive disease) ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
Was the chemotherapy regimen ever changed?	☐ Yes ☐ No ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
What is reason for chemotherapy regimen is changed?	☐ Adverse event to former chemotherapy. Specify adverse event: _____ _____ ☐ PD ☐ Patient preference ☐ Other (Specify): _____ ☐ Not recorded in the chart ☐ NA, chemotherapy was not given
What drug/s were used in this new chemotherapy regimen?	
Specify the total dose per drug per cycle for this new drug regimen used	☐ Total dose per drug per cycle: _____ ☐ Not recorded in the chart
What is the start date for this new chemotherapy regimen?	mm/dd/yyyy
How many cycles were given for this new chemotherapy regimen?	
What is the purpose for this new chemotherapy regimen?	☐ Adjuvant ☐ Neo-adjuvant ☐ Palliative ☐ Not recorded in the chart
What is tumor response for this new chemotherapy regimen? (Choose one by checking the appropriate box)	☐ NED ☐ CR ☐ PR ☐ SD ☐ PD ☐ Not recorded in the chart
Was radiotherapy advised?	☐ Yes, it is recorded in the chart ☐ No, it is recorded in the chart ☐ It is not documented in the chart

If RT was advised, was radiotherapy given?	☐ Yes, it is recorded in the chart ☐ No, it is recorded in the chart ☐ It is not documented in the chart
Was supportive care given?	☐ Yes, it is recorded in the chart ☐ No, it is recorded in the chart ☐ It is not documented in the chart
If answer is "yes," specify supportive care (May choose more than one)	☐ Pain control (Specify): _____ ☐ Nutrition build-up ☐ Rehabilitation from a sequelae of the treatment ☐ Psychological counseling ☐ Psychiatric intervention ☐ Religious/faith counseling ☐ Referral to Civil Society Organization ☐ NA, supportive care was not given ☐ NA, it is not documented in the chart

III. Breast Cancer Survival Status

Date of survival assessment	mm/dd/yyyy
What is the status of this patient at this date	☐ Alive
	☐ Died
	☐ Lost to follow-up[1]
	☐ Not recorded in the chart
When was date of last follow-up?	☐ mm/dd/yyyy ☐ Not recorded in the chart
What is the status of this patient at this last follow-up date?	☐ Alive, NED
	☐ Alive with residual small lesions, on definitive treatment
	☐ Alive with residual small lesions, without definitive treatment
	☐ Alive with residual big lesions, on definitive treatment
	☐ Alive with residual big lesions, without definitive treatment
	☐ Alive with terminal disease, only on supportive treatment
	☐ Not recorded in the chart
If died, when was date of death?	☐ mm/dd/yyyy ☐ Not recorded in the chart
If died, what is cause of death?	☐ Breast cancer-related ☐ Not cancer-related ☐ Not recorded in the chart

[1] Lost to follow-up means the patient has not come back as advised for immediate next treatment visit or within 12 weeks from last patient-attended clinic visit. Visiting the clinic for a treatment more than 12 weeks from advised scheduled treatment visit renders the patient lost to follow-up. The contracted healthcare institution is required to submit a sworn declaration for all their breast cancer patients who are "lost to follow-up."

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Case No. _____

Annex "P – Additional Services"

LIST OF ADDITIONAL SERVICES FOR COMPLICATED CASES

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

This form shall be accomplished completely by the contracted healthcare institution for cases which they assessed to be complicated in order to provide PhilHealth pertinent data on additional services that are not included in the Z benefit package listed above. Use additional sheets if needed.

Diagnostics/Labs	Indication	Frequency	Hospital charge/Amount(Php)

Procedure/s	Indication	Frequency	Hospital charge/Amount(Php)

Drug/s (Generic and Brand Name)	Indication	No. of units consumed	Hospital charge/Amount(Php)

Sub-specialty Referral	Reason/s for referral	Professional fee (Php)

Other services	Indication	Hospital charge/Amount(Php)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.