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

PHILHEALTH CIRCULAR
No. 2016 - 0021

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

SUBJECT : **"PD FIRST" Z BENEFITS: THE Z BENEFITS FOR END-STAGE RENAL DISEASE REQUIRING PERITONEAL DIALYSIS *(REVISION 1)***

I. BACKGROUND

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

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

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

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

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II. RULES FOR THE PD FIRST Z BENEFITS

1. *Accredited healthcare institutions (HCI) offering dialysis should inform and educate their end-stage renal disease (ESRD) patients of all options or modalities of artificial renal replacement therapy. If without medical contraindication to peritoneal dialysis, HCIs are strongly encouraged to actively offer this modality as the first line of treatment for their patients requiring dialysis.*

2. *Accredited HCIs* must screen all ESRD patients *on chronic continuous ambulatory peritoneal dialysis (CAPD), both adult and pediatric,* for qualification to the **PD First Z Benefits**. If qualified, these patients shall at all times be enrolled in this program.

   Note:
   a) *Case rates for PD shall be limited to acute kidney injury with indications for renal replacement therapy (e.g. leptospirosis);*
   b) *Insertion of PD catheter/PD initiation shall be a separate benefit under other applicable benefits of PhilHealth, such as case rates (ACR)*

3. PhilHealth members and their qualified dependents *to be enrolled into* the **PD First Z Benefits** must be eligible at the time of *availment of benefits.*

4. Pre-authorization for the **PD First Z Benefits** of eligible ESRD patients shall be required yearly. *The patient, however, shall be re-evaluated on the second year of undergoing peritoneal dialysis regarding plans for kidney transplantation, unless with medical contraindication to kidney transplantation (e.g. cancer).* The Pre-authorization checklist and request for the PD First Z Benefits (Annex "A") and the Member Empowerment Form or ME Form (Annex "B") shall be required for pre-authorization.

5. All requests for pre-authorization shall be completely and properly accomplished by the *accredited* PD provider *who shall submit the document request* to the Head of the Regional Benefits Administration Section (BAS) for approval.

6. *The approved Pre-authorization Checklist and Request (Annex "A") shall be valid for 60 calendar days from the date of approval by PhilHealth. All accredited PD providers are responsible for tracking the validity of their approved pre-authorizations. They shall inform PhilHealth immediately if pre-authorization requests lapsed. They can, however, submit a new pre-authorization checklist and request, if needed.*

7. *The* No Balance Billing (NBB) policy shall be applicable *for the Sponsored Program members* as stipulated in PhilHealth Circular 3, series of 2014 (Strengthening the Implementation of the No Balance Billing Policy). Negotiated co-pay shall be applied for eligible non-sponsored members and their qualified dependents.

8. *Patients shall be required to follow-up with their attending PD provider at least every month without fail to ensure adequate dialysis and to encourage and to make patients aware that the PD solutions are for their personal use only.* PD solutions shall be given to the patients by the *accredited* PD provider during such visits at a pre-determined schedule set by the Corporation.

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9. Under the **PD First Z Benefits,** the patients shall not be allowed to sell the PD solutions given to them. Patients found liable of selling PD solutions shall forfeit all the privileges of availing benefits under Z, without prejudice to the filing of appropriate charges for possible violation of Section 166 of the Implementing Rules and Regulations of R.A. 7875, as amended. This information must be understood and agreed upon by the patient and must be explained clearly by the *accredited* PD Provider. The patient signifies his agreement to this provision by affixing his signature *or thumbmark* in the Member Empowerment Form or ME Form. (Annex "B").

10. *Accredited PD providers are highly encouraged to conduct* house visits to ensure that patients and their caregivers continue to carry out the proper techniques and standards that should be observed during PD exchanges. Such visits will also serve as a means to assess the adequacy of dialysis and to ensure that PD solutions are used solely by the patients. *The Corporation shall independently conduct house visits at random in order to gather data that are relevant to policy and benefits enhancements (Annexes "D" and "L-PD First").*

11. All mandatory services and supplies under the **PD First Z Benefits** shall be given according to current standards of practice in order to ensure adequate dialysis. *Minimum s*tandards of care for peritoneal dialysis *are established* by *PhilHealth in collaboration with* the Reference Health Care Institution (HCI) and *experts.*

12. *Accredited* PD *p*roviders are required to have a patient logbook and/or electronic medical record of all their PD patients. For standardization, the contents of the electronic medical record shall be set by the Reference HCI and *experts and* approved by PhilHealth.

13. The *accredited* PD *p*roviders shall provide all patients under the **PD First Z Benefits** with a **PD passport.** (Annex "F") This document shall serve as the patient record. PD passports shall only be issued to patients with an approved pre-authorization request.

14. *Accredited PD providers should have an electronic file of all their patients' PD passports. These files shall serve as source of data for validation during field monitoring of PhilHealth.*

15. Based on the **PD Passport,** all patients shall be registered by the *accredited* PD provider according to the system that shall be set by PhilHealth. This system shall ensure that all **PD First Z** patients shall be monitored and tracked for relevant patient outcomes and other parameters set by the Corporation.

16. Professional *fees are inclusive of the package rate and additional administrative and service* fees *such as handling and delivery of PD bags to patient's home, among others,* shall be reflected *as the negotiated co-pay in* the individual contracts of PD providers.

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

18. All rates are inclusive of government taxes.

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19. Patients enrolled in the **PD First Z Benefits** shall be deducted a maximum of five (5) days from the 45 days annual benefit limit regardless of the actual number of PD exchanges in a calendar year. Such deductions shall be made on the current year when the pre-authorization is approved. In cases where the remaining annual benefit limit is at *least one (1) day at* the time of pre-authorization, the member shall remain eligible to avail of the **PD First Z Benefits,** provided that premiums are updated.

20. Hospital confinements secondary to the nature of the end-stage renal disease condition of patients under the **PD First Z Benefits** shall be covered under other applicable benefits of PhilHealth, *such as case rates.*

21. All claims for the **PD First Z Benefits** shall be filed by the *accredited* PD provider according to the schedule set by PhilHealth stated in Part IV of this Circular.

22. The filing of claims shall be done within 60 days from the last day of the applicable tranche.

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

24. Coordination and collaboration with the Reference HCI and among *accredited* PD Providers shall be required for operational and administrative purposes, such as, but not limited to, **patient referrals, clearance from referring PD provider prior to transfer of patient to other PD providers, patient tracking, pooled procurement of PD solutions, PD trainings,** ***and*** **regular patient audits,** ***among others.***

25. PD patients who wish to transfer to another PD provider shall express their intention by accomplishing the Letter of Intent for transfer of PD care to a Referral PD provider (Annex "G") in triplicate. *As proof of their intention to transfer, p*atients shall submit this letter to their referring PD provider, to the referral PD provider and to the Benefits Administration Section of the PhilHealth Regional Office *whose* jurisdiction is within the referring PD provider.

26. PD patients who shall transfer to other *accredited* PD *p*roviders are required to have a Checklist for Patient Transfer (Annex "M") properly accomplished by their referring *accredited* PD *p*rovider to be submitted to the referral PD provider. The referral PD provider should be notified in advance within a reasonable period of time by the referring PD provider of the plans to transfer a PD patient. The PD Passport (Annex "F") shall likewise be required for referrals to other *accredited* PD *p*roviders to give information as to the record of PD exchanges and the number of bags of PD solutions issued to the patient.

27. The *accredited* PD *p*rovider shall ensure adequate supply of PD solutions *for their PD* patients and proper inventory to prevent stock-outs.

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28. *All patients under the PD First Z Benefits who were shifted to HD for whatever reason shall be subject to monitoring. HCIs that provide hemodialysis services to PD patients are required to submit the list of these patients to the Benefits Administration Section (BAS) of the PhilHealth Regional Office (PRO) for endorsement to the Benefits Development and Research Department (BDRD).*

29. *PD patients enrolled in the Z Benefits who are admitted in accredited HCIs for the management of peritonitis and/or uremia is grounds for close monitoring and investigation to determine underlying reasons for confinement, such as non-adherence to the PD prescription and non-compliance to the standards of performing PD.*

30. All patients 50 years of age and above who are under the **PD First Z Benefits** are eligible to avail of pneumococcal vaccination as stipulated in PhilHealth Circular 7, series of 2014 (**Guidelines for the Oks ang Bakuna ko Laban sa Pulmonya**).

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

1. The package code is **Z012**, *with an* ICD-*10 Philippine Modification* code for *chronic kidney disease (CKD) Stage 5, of N18.5* and RVS code for peritoneal dialysis *of* 90945.

2. The package rate shall be P270,000 per year.

3. *Criteria for enrolment into the PD First Z Benefits:*

    a. Patients must have a permanent peritoneal dialysis *(PD)* catheter properly placed in the abdominal cavity. *(Note: Insertion of the PD catheter is a separate benefit from the PD First Z Benefits.)*

    b. Patients must have completed PD initiation in an accredited healthcare institution so that the patient is no longer uremic, with stable vital signs and adequately trained (patient himself/herself or a caregiver) to perform PD at home using manual exchanges.

    c. *No contraindications to peritoneal dialysis, such as the following:*

        i. disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen;
        ii. any inflammatory bowel diseases (ex. Crohns' disease, ulcerative colitis or diverticulitis);
        iii. any intra-abdominal tumors or intestinal obstruction;
        iv. active serositis;
        v. known or suspected allergy to PD solutions

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

a. PD supplies as follows
   i. PD solutions
      - PD double bag system 2.0 liters
      - Dextrose concentrations: 1.5%, 2.25% or its equivalent, 4.25%
      - Calcium content: Low calcium (1.25mmol/liter) or regular calcium (1.75mmol/liter)
   ii. PD accessories
      - Transfer set –changed every 6 months only
      - Caps (ie., Disconnect cap, Minicap)

b. Minimum standard of PD exchanges per day for benefit coverage

i. The principles and minimum standards on the manner of PD exchanges are the same for both adult and pediatric patients. PD fluid contained in the 2-liter bags is for single use only.

ii. *For benefit coverage and reimbursement purposes, PD patients are provided with three (3) 2-liter bags per day.*

5. The following supplies are **excluded** from the **PD First Z Benefits** package:
   a. Change of transfer set due to contamination;
   b. Y set (i.e. Andy disc);
   c. Use of cycler for automated peritoneal dialysis; and
   d. 5-liter bag PD solutions

6. *The benefit coverage* shall be two hundred seventy thousand pesos (P270,000) *for one (1) year. Payments shall be in tranches and shall be given directly to the accredited PD provider.* Every tranche payment covers the prescribed number of PD exchanges for 14 days.

Table 1. Amount per tranche and filing schedule

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

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IV. CLAIMS FILING

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

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

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

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

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

4. *Claims for the succeeding tranches for the rest of the calendar year shall be processed independently without reference to the previous tranche of PD claim and shall be paid provided that all mandatory services were provided as evidenced in the forms that are completely accomplished by the accredited PD provider and in order at the time of submission to PhilHealth.*

5. *The accredited PD provider should ensure at all times the accuracy of the forms submitted to PhilHealth. This includes the inclusion dates of PD exchanges in order to avoid overlapping dates for the PD claims. In the event of overlapping dates, the previous tranche shall be paid but the succeeding tranche with the overlapping date/s with the previous tranche shall automatically be denied.*

   Example:
   a) PD 3rd tranche inclusion dates: Aug 4 to 17, 2015
   b) PD 4th tranche inclusion dates: Aug 16 to 29, 2015
   c) Overlapping PD session dates are Aug 16 and Aug 17
   d) PD 4th tranche shall be denied

6. *In the event that the PD patient is admitted in an accredited HCI for service provisions other than peritoneal dialysis, the tranche claim for PD shall be paid, provided that all mandatory services for PD were provided and the required tranche documents are in order when submitted to PhilHealth. PD should NOT be filed as 2nd case rate.*

   Accredited HCIs should allow patients under the PD First Z Benefits to bring in their PD solutions during confinement. If patients cannot bring their PD solutions, the HCI should discuss with the patients and/or their family all options to continue the PD exchanges while admitted in the hospital.

   Example:
   a) PD 3rd tranche inclusion dates: August 4 to 17, 2015
   b) Patient is admitted on August 5 due to pneumonia and discharged on August 9
   c) Pneumonia shall be filed as a separate claim

7. *Claims with less than 14 days during the last month of the calendar year shall be paid on a pro-rated basis*
   a) PD 26th tranche inclusion dates: December 23 to 31, 2015
   b) The system pays the 26th tranche on a pro-rated basis

8. *In the event that a patient under the PD First Z Benefits is confined in an accredited HCI and would need to be shifted to hemodialysis (HD), the tranche claim for PD shall be paid provided*

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that all mandatory services for PD were provided and the required tranche documents are in order when submitted to PhilHealth.

Patients under the PD First Z Benefits are not allowed to file HD claims directly to PhilHealth. It shall be the responsibility of the HCI where the HD was provided to file the appropriate claim to PhilHealth. The HD claim shall be paid directly to the accredited HCI. The claim for HD should not overlap with the claim for PD.

9. *All accredited PD providers shall submit a monthly report of expired patients to the BAS of the PRO. For appropriate tagging, the list of expired PD patients or deceased members shall be endorsed to the Member Management Group.*

   To validate deaths, PhilHealth may check the names of pre-authorized PD patients with the Philippine Statistics Authority (PSA). Claims for PD of expired or deceased patients constitute violation of the provisions of the Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and 10606) and shall be dealt with accordingly.

10. *When a patient transfer to another accredited PD provider, the tranche claim for PD of the referring PD provider shall be paid provided that all mandatory services for PD were given and the required tranche documents are in order when submitted to PhilHealth.*

    The initial tranche claims of the referral PD provider where the patient transferred shall be paid provided that all mandatory services were given, all required forms are complete and in order, which includes a photocopy of the letter of intent for transfer of PD care (Annex "G") and a copy of the checklist for patient transfer (Annex "M").

V. REPEALING CLAUSE

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

VI. *TRANSITORY CLAUSE*

Claims filed with approved pre-authorizations prior to the date of effectivity of this circular shall follow the provisions of PhilHealth Circular 018-2014.

VII. EFFECTIVITY

This circular shall take effect fifteen (15) calendar days after its publication in *the Official Gazette or in* a newspaper of general circulation and *shall be* deposited thereafter at the Office of the National Administrative Register, University of the Philippines Law Center.

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ALEXANDER A. PADILLA
President and CEO

Date signed: 6/30/2016

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Case No. _____ **Annex A – PD First**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
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, HCI to specify reason/s *and encode*
_____

PRE-AUTHORIZATION CHECKLIST
PD First Z Benefits

(Place a ✓if YES)

QUALIFICATIONS	YES
For pediatric patients, aged 0 to 18 years and 364 days, written informed consent from the parents or guardian is secured.	

Conforme by Patient/Parent/Guardian

_____
Printed name and signature

ATTESTED BY ATTENDING NEPHROLOGIST

(Place a ✓if YES)

QUALIFICATIONS	YES
Diagnosed with end stage renal disease (ESRD) requiring renal replacement therapy, *except for acute kidney injury (e.g. leptospirosis)*	
Has a permanent Tenkchoff peritoneal dialysis catheter properly placed in the abdominal cavity	
Has completed PD initiation in *an accredited health care institution*	
No longer uremic, with stable vital signs	
Patient and/or a caregiver have adequate training to perform PD at home using MANUAL exchanges.	
Absence of any disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen	

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QUALIFICATIONS	YES
Absence of any inflammatory bowel diseases (Crohns' disease, ulcerative colitis or diverticulitis)	
Absence of any intra-abdominal tumors or intestinal obstruction	
Absence of active serositis	
Absence of known or suspected allergy to PD solutions	

Certified correct by Attending Nephrologist:

_____
Printed name and signature

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

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form 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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Case No. _____

PRE-AUTHORIZATION REQUEST
PD First Z Benefits

DATE OF REQUEST (mm/dd/yy):

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 _____

Conforme by Patient/Parent/Guardian:	Certified correct by: (for Service Patients)
(Printed name and signature)	(Printed name and signature) Please tick appropriate box ☐ *Head, Peritoneal Dialysis Unit* OR ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ 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)

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:		

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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	

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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.		

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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.		

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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

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H. Sketch of Home Address with Landmark
As part of the continuing efforts of PhilHealth to improve the benefits delivery and services, I am providing the following information for the sole purpose of conducting home visits to patients who availed of the Z Benefits: (Please draw a sketch of your home address below.) Landmark/s: _____ Nearest National Road (as applicable): _____ Nearest Church, School or Establishment (if any): _____ Nearest Barangay Hall: _____ Other information to guide directions to your home: _____

I. Consent to access patient record	J. 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

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Case No. _____

Annex "C – PD First"

PD FIRST Z BENEFITS CHECKLIST OF SERVICES PROVIDED

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

I. PD double bag system		
A. Number of bags and glucose content (indicate the number of bags on the blank) _____ *1.5%* _____ *2.5 % or 2.3 %* _____ *4.25%*	*B. Number of exchanges covered by PhilHealth per day (place a ✓ opposite appropriate answer)* _____ *3* _____ *4*	C. Calcium content (place a ✓ opposite appropriate answer) _____ Low _____ Regular
II. PD accessory ☐ Transfer set given* * Quantity: 2 per year, every six (6) months only		

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician/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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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

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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

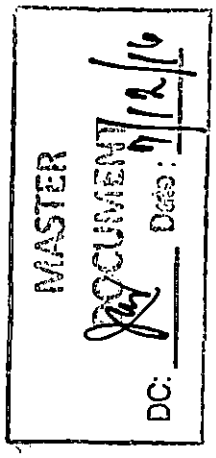
9. If you have other comments, please share them below:

   _____

   _____

   _____

Thank you. Your feedback is important to us!



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Case No. _____

Annex E – PD First

TRANCHE REQUIREMENTS CHECKLIST
PD FIRST Z BENEFITS

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

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

TRANCHE REQUIREMENTS	Status
I. To be submitted once a year, upon filing claims for the 1st tranche	
a. Original copy of approved Pre-authorization Checklist and Request *(Annex A-PD First)*	
b. *Photocopy* of completely accomplished Member Empowerment (ME) Form *(Annex B)*	
c. Completed PhilHealth Claim Form (CF) 1 *or PhilHealth Benefit Eligibility Form (PBEF)** and CF 2	
II. To be submitted every filing of tranche (every two weeks)	
a. *Transmittal Form (Annex H)*	
b. Accomplished Tranche Requirement Checklist *(Annex E-PD First)*	
c. Accomplished PD First Z Benefit Checklist of Services Provided *(Annex C-PD First)*	
III. To be submitted along with the last tranche application for the calendar year	
Z Satisfaction Questionnaire *(Annex D)*	

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

Date Completed:
Date Filed:

MASTER DOCUMENT DC: Date: 7/12/16

Certified correct by:**	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Nephrologist	(Printed name and signature) Please tick appropriate box ☐ *Head, Peritoneal Dialysis Unit OR* ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ 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)

**for CO-PAY PATIENTS, the signature of the Attending Nephrologist is sufficient.

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Annex F – PD First

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

PD FIRST PASSPORT

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

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Annex "G – PD First"

DATE (mm/dd/yyyy)
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

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

This is to certify that I, _____, born on _____,
(Name of Patient) *(Date of Birth)*
age _____ years old, residing at _____,
(Address)
was diagnosed with End Stage Renal Disease and was initiated on peritoneal dialysis at the
_____ on _____.
(Name of Referring PD Center) *(Date of PD Initiation)*
I perform _____ exchanges per day. I would like to request for transfer of PD Care to
(indicate number)
_____ under the care of _____.
(Name of Referral PD Center) *(Name of Nephrologist)*

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

Conforme by:	Certified correct by:
(Printed name and signature) Patient/ Parent/ Guardian	(Printed name and signature) Nephrologist, Referring PD Center PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐-☐
Certified correct by:	Certified correct by:
(Printed name and signature) Billing Representative, Referring PD Center	(Printed name and signature) PD Coordinator, Referring PD Center
Acknowledged by:	Acknowledged by:
(Printed name and signature) Head/PD Coordinator, Referral PD Center	(Printed name and signature) BAS Head, PhilHealth Regional Office ____

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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.

MASTER DOCUMENT Date: 9/12/16 DC:

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)		

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Case No. _____

Annex "M – PD First"

CHECKLIST FOR PATIENT TRANSFER
PD First Z Benefits

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

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

NAME OF REFERRAL PD CENTER
ADDRESS OF REFERRAL PD CENTER

Requirements	Yes OR No (tick appropriate box)	Signature of Responsible Person
1. Updated Medical Abstract	☐ Yes ☐ No	Name & signature Attending Nephrologist
2. Updated PD Prescription for one (1) month	☐ Yes ☐ No	
3. Letter of Referral from Attending Nephrologist/ Fellow	☐ Yes ☐ No	
4. Clearance from PD Provider re status of utilization of PhilHealth PD First Z Benefits Claims	☐ Yes ☐ No	Name & signature Billing Personnel
5. Letter of Intent from Patient requesting for transfer to a referral PD Provider (Annex G)	☐ Yes ☐ No	Name & signature Patient/Parent/Guardian
6. Submission of PD Passport (Annex F) to Provider	☐ Yes ☐ No	Name & signature PD Coordinator

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

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

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Annex "L-PD First"

Control Number: _____

FIELD SURVEY TOOL FOR PD FIRST Z BENEFITS

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 benefits at malaman din kung naging sapat ba ang PhilHealth benefit na natanggap ninyo.

Na-identify 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-enroll ng *(state the hospital)* sa ilalim ng PD FIRST Z Benefits noong *(state month and year)*.

Isasagawa natin ang interview na ito sa mahigit kumulang ng 20 minutes. Hindi kami hihingi ng kahit anong personal na impormasyon sa inyo maliban lamang sa mga mahalaga para sa Z benefits. 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).*

I. PATIENT INFORMATION

A. **Name of Patient (initials):** _____

B. **Permanent Address:** _____
_____

C. **Phone Number/s:**
1. _____
2. _____
3. _____

D. **Email address/es:**
1. _____
2. _____

E. **PhilHealth membership status:**
☐ Member ☐ Dependent

F. **Employment status:**
Currently working ☐ Yes ☐ No
If yes, nature of work:
_____
If no, who supports patient:
_____

G. **Age** (in years) : _____

H. **Birthdate:** _____
(mm/dd/yyyy)

I. **Sex:** ☐ Male ☐ Female

J. **Marital status of patient:**
☐ Single
☐ Legally married
☐ With partner
☐ Widow/ widower (encircle)

K. **Educational status of patient:**
☐ Elementary
☐ High school
☐ College
☐ Vocational
☐ Post Graduate
☐ Others: specify _____

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II. RESPONDENT INFORMATION (if respondent is not the patient)

A. **Name of Respondent:**
(Last name, first name, middle initial, extension)
_____

B. **Relationship to patient:**
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

C. **Age** (in years) : _____

D. **Sex:** ☐ Male ☐ Female

E. **Educational status of patient:**
- ☐ Elementary
- ☐ High school
- ☐ College
- ☐ Vocational
- ☐ Post Graduate
- ☐ Others: specify _____

III. INFORMATION ON CONTACT PERSON, PERSON TRAINED ON PD, AND CAREGIVER

A. **Name of contact person:**
(Sino ang pwede tawagan kung may kailangan pang impormasyon?)
_____

Relationship to patient:
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

Permanent Address of contact person:
_____
Contact Number/s of contact person:
_____

B. Were you (pertaining to the patient) trained to do the PD exchanges?
(Na-train po ba kayong mag-PD?)
☐ Oo ☐ Hindi

C. Name of the person trained on PD aside from the patient: (Bukod sa inyo, sino pa po ang na-train na mag-PD?)
_____

Relationship to patient:
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

Permanent address of the person trained on PD:
_____
Contact Number/s:
_____

D. **Who takes care of you?**
(Sino ang nag-aalaga sa inyo?)

Relationship to patient:
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

E. Is the the person doing your PD exchange the same person who was trained by the PD facility's (PD Unit, NKTI or other PD facility) PD Nurse?
(Siya din po ba ng na-train sa PD)
☐ Oo ☐ Hindi

If NO, who trained the person doing your PD exchanges now?
(Kung HINDI, sino ang gumagawa ng PD sa inyo?)
_____

Educational status of the person doing your PD exchanges now:
- ☐ Elementary
- ☐ High school
- ☐ College
- ☐ Vocational
- ☐ Post Graduate
- ☐ Others: specify _____

MASTER DOCUMENT Date: 7/12/16 DC:

IV. OTHER INFORMATION ON PD OF THE PATIENT

A. Date of PD catheter insertion
(Kailan inilagay ang PD catheter?)
(mm/dd/yyyy) :_____

B. Date of PD initiation
(Kailan nagsimula ang PD?) (mm/yyyy):
_____
Name and address of HCI where PD was initiated
_____
_____

C. Number of PD exchanges/day
(Ilang beses isinasagawa ang PD sa isang araw):
☐ 3 exchanges/day
☐ 4 exchanges/day
☐ Others: _____
☐ Who does the PD of the patient?

D. Who does the PD of the patient?
(Sino ang gumagawa ng PD niyo?)
☐ Patient
☐ "Caregiver"
☐ Others:_____

E. How much PD solution is infused through the PD catheter per PD exchange?
(Gaano karaming PD solution ang ipinapasok sa tiyan?)
☐ 1 liter
☐ 2 liters
☐ Others: _____

F. How many PD exchanges did your doctor prescribe to you?
(Ilang PD exchanges ang kailangan niyong gawin base sa reseta sa inyo ng doctor?) _____

G. How many PD boxes are supplied by the contracted health care institution per two weeks?
(Ilang PD boxes ang binibigay sa inyo ng ospital o clinic kada dalawang linggo?)
_____bags kada dalawang linggo

H. If with excess PD bags/boxes, what does the patient do with them?
(Kung may sobrang PD bags/boxes, anong ginagawa ninyo sa mga ito?
_____

I. Approximate number of episodes of infection (peritonitis) since PD initiation?
(Ilang beses kayong nagka-infection mula ng magsimula kayong mag-PD?) _____

J. Approximate number of episodes of infection (peritonitis) since enrolment into the PD Z Benefits?
(Ilang beses kayong nagka-infection mula ng ma-enrol kayo sa PD First Z Benefits?) _____

K. Daily activities

Maligo	☐May tulong	☐ Walang tulong
Maglinis ng bahay	☐Oo	☐Hindi
Maglaba	☐Oo	☐Hindi
Magluto	☐Oo	☐Hindi
Mamasyal (ex. mag-mall)	☐Oo	☐Hindi
Magtrabaho	☐Oo	☐Hindi
Mag-aral (if student)	☐Oo	☐Hindi
Bedridden (nakaratay)	☐Oo	☐Hindi

Others: (May iba pa ba kayong ginagawa bukod sa mga nabanggit gaya ng sports, gardening, exercise, etc._____

V. INFORMATION ON PD TECHNIQUE

A. Kayo ba ay naturuan ng pamamaraan ng peritoneal dialysis (PD)?
☐ Oo ☐ Hindi

B. Kung naturuan, sino ang nagturo?
☐ Doctor
☐ Nurse
☐ Others: _____

C. Naghuhugas po ba kayo ng kamay bago mag-PD?
☐ Oo ☐ Hindi

Kung OO, ano ang ginagamit sa paghugas ng kamay?
☐ Tubig at sabon
☐ Alcohol
☐ Hand sanitizer

Kung OO, gaano kadalas maghugas ng kamay?
☐ Palagi
☐ Minsan

D. Nagsusuot po ng mask habang gumagawa ng PD?
☐ Oo ☐ Hindi

Kung OO, gaano kadalas magsuot ng mask habang gumagawa ng PD?
☐ Palagi
☐ Minsan

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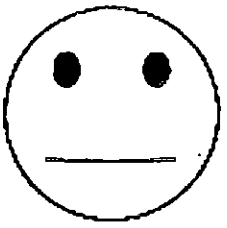
VI. ADAPTATION SKILLS

Ano ang pakiramdam mo sa iyong pagda-dialysis? (Markahan ng X)

☐ Ako ay umaasang gagaling din



☐ Wala akong nararamdaman o pakialam

☐ May pagkakataon na ako'y nalulungkot o nade-depress

☐ Wala na akong pag-asang gumaling

VII. FUTURE PLAN FOR KIDNEY TRANSPLANTATION

1. May idea ba kayo kung ano ang kidney transplantation? ☐ Meron ☐ Wala
   (Kung "wala" proceed to VIII)
2. Kung "meron" and sagot, may plano po ba kayo na magpa-kidney transplant? ☐ Meron ☐ Wala
3. Kung "meron" ang sagot sa no. 2, kailan ninyo balak magpa-kidney transplant? _____
4. Kung "wala" ang sagot sa no. 2, bakit wala kayong balak na magpa-kidney transplant?
   _____
   _____

VIII. SATISFACTION

A. Aling ospital or pasilidad ang nag enroll sa inyo sa PD First Z benefits?
   _____

B. Kayo ba ay nasiyahan sa serbisyong natanggap ninyo mula sa ospital o pasilidad na nagbigay ng Z benefits?
   ☐ Oo ☐ Hindi

C. Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap ninyo?
   _____
   _____

D. Kung hindi kayo nasiyahan, anu-anong dahilan?
   _____
   _____

E. Kung kayo ay nasiyahan sa serbisyong PD na inyong natanggap, paano ninyo isasalarawan ang inyong kasiyahan? (Markahan ng X)

☐ Lubos na masaya

☐ Masaya

☐ Di masaya

MASTER DOCUMENT

IX. PHILHEALTH BENEFIT

A. May binayaran ba kayo mula ng kayo ay na-enroll sa PD First Z benefits? ☐ Meron ☐ Wala

B. Kung "meron" anu-ano ang mga binayaran ninyo at magkano?

Item	Amount

C. May binayaran ba kayong professional fee ng doctor? ☐ Meron ☐ Wala

D. Kung "meron" magkano po ang binabayaran professional fee ng doctor kada check-up?_____

E. Naitago po ba ninyo ang mga resibo ng mga binayaran? ☐ Oo ☐ Hindi

F. Kung "oo," pwede po ba naming makita ang mga resibo at mailista o makuhanan ng picture ang mga ito?
☐ Oo ☐ Hindi

Item	Amount indicated in receipt

X. MODE OF TRANSPORTATION

A. Ano ang gamit ninyong sasakyan papunta ng ospital o pasilidad ng PD tuwing check-up:

☐ Public , specify _____
☐ Private, specify: _____
☐ Sariling sasakyan
☐ Nirerentahan
☐ Ambulance
☐ Barangay/other government vehicles
☐ Naglalakad lang

B. Ano ang gamit ninyong sasakyan papunta ng ospital o pasilidad ng PD para mag -pick-up ng PD bags:

☐ Public , specify _____
☐ Private, specify: _____
☐ Sariling sasakyan
☐ Nirerentahan
☐ Ambulance
☐ Barangay/other government vehicles
☐ Naglalakad lang

XI. PATIENT COMMENTS

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

_____

_____

B. May nais ba kayong imungkahi para mapabuti pa ang serbisyo ng ospital o pasilidad ng PD?

_____

_____

MASTER DOCUMENT
DC: ___ Date: 11/14/14

XII. SURVEYOR OBSERVATIONS

A. General appearance of the patient
Ambulatory ☐ Oo ☐ Hindi
(Nakakatayo / Nakakapaglakad)

Naka-wheelchair ☐ Oo ☐ Hindi
Bedridden ☐ Oo ☐ Hindi
Inaantok ☐ Oo ☐ Hindi
Malinis sa katawan ☐ Oo ☐ Hindi
Matamlay ☐ Oo ☐ Hindi
Others: _____

B. Is patient doing PD exchange at time of home visit? ☐ Yes ☐ No

C. Is there a specific area in the house where the patient performs the PD exchanges?
☐ Yes ☐ No ☐ NA ☐ Don't know

D. If yes, is the area free from clutter, dirt and dust?
☐ Yes ☐ No

E. Is there source of water for handwashing?
☐ Yes ☐ No

F. Is there adequate lighting? ☐ Yes ☐ No

G. Is there area for storage of PD solutions?
☐ Yes ☐ No

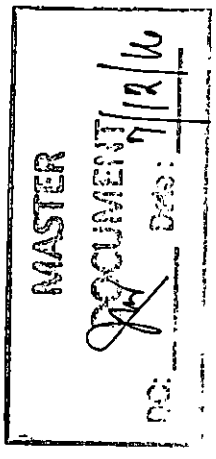
H. If yes, is it free from:
bug infestations ☐ Yes ☐ No
water damage/dampness ☐ Yes ☐ No

I. Number of unused PD bag/s: _____

J. Number of used PD bag/s: _____

K. Number of Andy disk/s: _____

Name of interviewer: _____ Designation: _____
Name of documenter: _____ Designation: _____
Date of interview (mm/dd/yyyy): _____ Time of interview: _____



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CLINICAL PATHWAY
PERITONEAL DIALYSIS INITIATION

GENERAL CONTRAINDICATION TO PERITONEAL DIALYSIS:
- Presence of abdominal surgery
- Patient is untrainable and without any relative or caregiver available for training
- Known active psychiatric disorder

PATIENT'S NAME:			DATE OF BIRTH			
						HOSPITAL NO.
LAST NAME	FIRST NAME	MIDDLE NAME	MM	DD	YR	
DIAGNOSIS:	DATE: _____ TIME: _____					PHILHEALTH NO. (Parent / Guardian)
			AGE	SEX	STATUS	o *Member* o *Dependent* o *Others*
	PATHWAY ACTIVATED ON: _____					
	HOSPITAL					

CLINICAL NOTES	PHYSICIAN'S ORDERS	CARRIED OUT BY / TIME
SUBJECTIVE FINDINGS: o Generalized body weakness o Easy fatigability o Nausea o Vomiting o Difficulty of breathing o Inability to sleep o Decreasing urine output o Edema o Pallor o Change in behavior o Others: _____	**Laboratories:** o Complete blood count o BUN, Creatinine, Potassium o 12L – ECG o Chest - xray o Arterial blood gas o Whole Abdomen Ultrasound (if not yet done) o HIV Screening o HbsAg, anti – HCV o Others: _____ _____	
OBJECTIVE PHYSICAL FINDINGS: BP: _____ CR: _____ RR: _____ Wt: _____	**PD Access:** Refer to Surgeon for peritoneal dialysis catheter insertion Prophylactic antibiotics: _____	
	PD Prescription: O CAPD O CIPD OAPD _____ exchanges/day Fill volume: _____ Dwell time: _____ 1.5% _____ 2.3% _____ 4.25% _____	
	For CAPD Training	
	Special Orders:	

MASTER
DOCUMENT
DC: _____ Date: 7/12/16

Codes:
ESRD: N18
RVS for PDCI: 49420
RVS for Dialysis (PD): 90945

_____
Adult Nephrology Fellow on Duty

Clinical Practice Guidelines for Peritoneal Access.Peritoneal Dialysis International. Vol 30, pp 424-429.
ISPD Guidelines/ Recommendations, Peritoneal Dialysis-Related Infections, Recommendation: 2010 Update PD International, Vol 30 pp 393-423.
Handbook of Dialysis. 4th Edition, John T. Daugirdaspp 387-452.
KDIGO Clinical Practice Guidelines for AKI, Vol 2, issue 1. March 2012.

CLINICAL PATHWAY
CONTINUOUS AMBULATORY PERITONEAL DIALYSIS

Z-Benefit Package Code: _____

CLINICAL CRITERIA:
- Diagnosed End-Stage Renal Disease (ESRD) requiring renal replacement therapy
- Maintained on Chronic Ambulatory Peritoneal Dialysis with a functioning Tenckhoff PD catheter

PATIENT'S NAME:			**DATE OF BIRTH**	
LAST NAME / **FIRST NAME** / **MIDDLE NAME**			**MM** / **DD** / **YR**	**HOSPITAL NO.**
DIAGNOSIS:	**DATE:** _____ **TIME:** _____			**PHILHEALTH NO.** (Parent / Guardian)
	PATHWAY ACTIVATED ON: _____		**AGE** / **SEX** / **STATUS**	O *Member* O *Dependent* O *Others*
PD CATHETHER INSERTION:	**Hospital (*specify*):** _____	**Date:**	**AREA OF PD TRAINING:** O **In-patient (*specify*):**	
PD INITIATION:	**Hospital (*specify*):** _____	**Date:**	O **Out-patient**	

CLINICAL NOTES	PHYSICIAN'S ORDERS	CARRIED OUT BY / TIME
SUBJECTIVE FINDINGS: o Generalized body weakness o Easy fatigability o Nausea o Vomiting o Difficulty of breathing o Inability to sleep o Decreasing urine output o Edema o Pallor o Change in behavior o Others: _____	**Laboratories:** o Complete blood count o Creatinine, BUN, Potassium, Calcium, Phosphorus, Albumin, FBS/RBS o Others: _____ _____ _____	
OBJECTIVE PHYSICAL FINDINGS: BP: _____ CR: _____ RR: _____ Wt: _____	**PD Prescription:** **O CAPD** Number of exchanges / day: _____ Fill volume: _____ 1.5% _____ 2.3% _____ 4.25% _____	
	Special Orders:	

Codes:
ESRD: N18

MASTER DOCUMENT Date: 7/12/16 DC: _____

_____
Adult Nephrology Fellow on Duty

Clinical Practice Guidelines for Peritoneal Access.Peritoneal Dialysis Internations.Vol 30, pp 424-429.
ISPD Guidelines/Recommendations, Peritoneal Dialysis-Related Infections, Recommendation: 2010 Update PD International, Vol 30 pp 393-423.
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CLINICAL PATHWAY
PD – RELATED INFECTIONS

PD PERITONITIS	EXIT-SITE INFECTION (ESI)	TUNNEL INFECTION
Diagnostic Criteria (2 out of 3 criteria) • Symptoms and signs of peritoneal inflammation (eg: abd pain, abd tenderness) • Cloudy peritoneal fluid with an elevated peritoneal fluid count (>100cells/uL) predominantly neutrophils (>50%) • Demonstration of organism in the peritoneal effluent by gram stain or culture	**Diagnostic Criteria (2 out of 3 criteria)** • Erythema >10mm around the catheter exit site • Exudate from exit site • Positive culture from exudates around the exit site	• Recurrent exit-site infection • Erythema and tenderness around the catheter exit site

PATIENT'S NAME:			DATE OF BIRTH			
						HOSPITAL NO.
LAST NAME	FIRST NAME	MIDDLE NAME	MM	DD	YR	
DIAGNOSIS:	DATE: _____ TIME: _____					PHILHEALTH NO. (Parent / Guardian)
	PATHWAY ACTIVATED ON: _____		AGE	SEX	STATUS	O *Member* O *Dependent* O *Others*

PD CATHETHER INSERTION:	**Hospital (*specify*):**	**Date:**	**AREA OF PD TRAINING:**	O **In-patient (*specify*):**	**History of PD catheter infection**
PD INITIATION:	**Hospital (*specify*):**	**Date:**		O **Out-patient (Home Training)**	O **YES** O **NO**
WHO WAS TRAINED FOR PD?	O Patient O Others (*specify*): _____		O Both	**PERSON DOING EXCHANGES AT HOME:**	

CLINICAL NOTES	PHYSICIAN'S ORDERS	CARRIED OUT BY / TIME
SUBJECTIVE FINDINGS: o Abdominal pain o Cloudy dialysate o Fever o Nausea o Vomiting o Constipation o Others: _____	**Laboratories:** o Complete blood count o Potassium o Dialysate: Cell count / Diff count; Gram stain; Culture o Culture of catheter exit-site exudate (*for ESI*) o Ultrasound of catheter exit site (*for Tunnel Infection*) o Others: _____	
SPECIAL CASES: o **Recurrent Peritonitis** ➢ Different organism o **Relapsing Peritonitis** ➢ Same organism within a week of stopping antibiotics	**Therapeutics:** ***Antibiotics:*** O Oral (specify): _____ O Intravenous (specify): _____ O Intra-peritoneal (specify): _____ ***Others:*** _____	
OBJECTIVE PHYSICAL FINDINGS: BP: _____ CR: _____ RR: _____ Wt: _____	**PD Regimen:** Do in-and-out flushes using 1-Li PDS x 3 cycles (*for patients with severe abd pain & very cloudy dialysate*) **O CAPD** **O CIPD** **O APD** _____ exchanges / day Fill volume: _____ Dwell time: _____ 1.5% _____ 2.3% _____ 4.25% _____	
	Special Orders:	

MASTER

Codes:
ESRD: N18
Other Peritonitis: K65.8

_____
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