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 - 0033

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

SUBJECT : **EXPANDED Z BENEFIT FOR MOBILITY, ORTHOSIS, REHABILITATION, PROSTHESIS HELP PACKAGE (EXPANDED ZMORPH)**

I. RATIONALE

The Philippine Health Insurance Corporation recognizes the potential towards functional independence and productivity of persons with disabilities, particularly those with spinal or limb loss, deficiency or deformity once they are provided with affordable prostheses or orthoses.

Aligned with the mission of Republic Act 7277 or Magna Carta for Disabled Persons PhilHealth therefore seeks to mainstream persons with disabilities into the community by ensuring functionality through integration of prosthetic and orthotic devices provision with rehabilitation services.

Cognizant of the United Nations Convention on the Rights of Persons with Disabilities vision of full and equal enjoyment of PWDs' human rights PhilHealth shall ensure protection of their inherent dignity by ensuring provision of prosthetic and orthotic devices which are safe, appropriate, accessible and of quality.

Supportive of the Department of Health Administrative Order 2015-0004 (Revised National Policy on Strengthening the Health and Wellness Program for PWDs) that aims to remove barriers to health care access, PhilHealth expands scope of assistive technology from below the knee prosthesis to all levels of limb loss or deficiency and limb or spinal deformity with integrated rehabilitation services.

Pursuant to PhilHealth Board Resolution No. 2124 s. 2016, the ZMORPH shall be expanded to include benefits for prostheses, orthoprostheses and orthoses.

II. RULES FOR IDENTIFIED TYPE Z

1. The provision of services for Expanded ZMORPH shall be covered under the benefit package and only those cases that strictly fulfill the selections criteria shall be covered.

2. Contracted health care institutions (HCI) should assess all their patients for qualification to the Z benefits. If qualified, these patients should be enrolled in this program. Contracted HCIs shall be responsible for developing an efficient process for assessing Z benefit patients that is applicable in their own local setting.

3. Pre-authorization from PhilHealth based on the approved selections criteria shall be required prior to provision of services. All requests for pre-authorization shall be completely and properly accomplished by the contracted HCI by filling out the pre-authorization checklist and request (Annex "A") and submitted by a designated liaison of the contracted HCIs to the Local Health Insurance Office (LHIO) or to the office of the Head of the PhilHealth Benefits Administration Section (BAS) in the region for approval.

4. The approved Pre-authorization Checklist and Request (Annex "A") shall be valid for 180 calendar days from the date of approval by PhilHealth. All contracted HCIs are responsible for tracking the validity of their approved pre-authorizations. Contracted HCIs shall inform PhilHealth and shall submit a new pre-authorization checklist and request if services were not provided at the end of the validity period of the prior request.

5. While the submission of pre-authorization request is manual, the pre-authorization checklist and request for the Expanded ZMORPH and the properly accomplished Member Empowerment Form or ME Form (Annex "B") shall be submitted together. Once the systems are automated, a unique case number shall be generated for every pre-authorization request submitted.

6. The ME Form shall be accomplished together by the attending health care professional/s in the contracted HCI and the patient to be enrolled in the Expanded ZMORPH. The ME Form aims to support patients to be active participants in health care decision making by being educated and informed of the conditions, all management options. Further the ME Form aims to encourage the attending health care professionals in the contracted HCIs to dedicate adequate time to discuss with patients. The overall goal is to achieve better health outcomes and patient satisfaction.

7. PhilHealth members and their qualified dependents must be eligible to avail of PhilHealth benefits at the time of pre-authorization.

8. The minimum standards of care for Expanded ZMORPH cover the entire management from pre-prosthetic /orthotic assessment up to the conduct of the rehabilitation or occupational therapy sessions. These are based on current standards of practice and may be updated as needed depending on valid medical evidence that is transferrable and applicable to the local setting. Updating of medical evidence shall be covered during regular policy reviews in collaboration with pertinent stakeholders.

9. The minimum standards of care for the Expanded ZMORPH are the mandatory services (Table 3) that must be provided to all patients enrolled under the Z benefits in all contracted HCIs that shall be required by PhilHealth.

10. Coordination and collaboration with the Reference HCI and among contracted HCIs for Expanded ZMORPH shall be required for quality improvement and operational purposes, such as, but not limited to, pertinent trainings, regular patient audits, patient referrals, patient tracking, pooled procurement of medicines and supplies, etc.

11. Patients enrolled in the Expanded ZMORPH shall be deducted a maximum of five (5) days from the 45 days annual benefit limit regardless of the actual length of stay in the contracted HCI in a calendar year. Such deductions shall be made on the current year when the pre-authorization is approved. In cases where the remaining annual benefit limit is less than five (5) days but at least one (1) day at the time of pre-authorization, the member shall remain eligible to avail of the Z Benefits, provided that premiums are updated. Contracted HCIs should remind these patients to regularly update premium contributions in order to continue availing PhilHealth benefits.

12. The No balance billing (NBB) policy shall be applicable as stipulated in PhilHealth Circular 3, series of 2014 (Strengthening the Implementation of the No Balance Billing Policy) and other related issuance. Negotiated fixed co-pay shall be applied for eligible non-sponsored members and their qualified dependents. The fixed co-pay shall be reflected in the individual contracts and shall cover for additional services rendered by the contracted HCI in relation to the Expanded ZMORPH.

    If the eligible members or their qualified dependents refuse to avail of the NBB policy and agree to pay the negotiated co-pay, they will be allowed to do so provided they indicate in the Member Empowerment Form that they are willing to opt out from the NBB and pay the corresponding negotiated co-pay.

13. All claims for the Expanded ZMORPH shall be filed by the contracted HCI according to the schedules set by PhilHealth.

14. The filing of claims shall be done by the contracted HCI within 60 calendar days from the last day of the period covered specified in the tranche schedules in Table 4.

15. All mandatory and other services specific to the Expanded ZMORPH, that ensures the safety and material used, shall be provided to the patient according to the approved standards set by the reference HCI.

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

17. The professional fees for the Expanded ZMORPH is 10% of the package rate. Rules on pooling of professional fees for government facilities shall still apply.

18. All rates are inclusive of government taxes.

19. In cases when the patient expires anytime during the course of service provision or the patient is lost to follow-up, the payment schedule of the corresponding tranche for the specific phase shall be released as long as the patient received the scheduled service. The remaining tranche shall not be paid.

    "Lost to follow-up" means the patient has not come back as advised for immediate next rehabilitation treatment visit or within 2 weeks after prosthetic/orthotic prescription has been prescribed. Visiting the clinic for rehabilitation services more than 2 weeks from advised scheduled treatment visit renders the patient "lost to follow up."

If the patient has not come back within 4 weeks after the agreed schedule of follow up after casting and measurement or after fitting and alignment, and would require additional re-casting and measurement, the patient may proceed with the succeeding services for the Z Benefits but the hospital may collect additional for fees for casting and measurement.

Patient will only be allowed a maximum of one calendar year to avail of the Z benefits from casting to rehabilitation services.

20. Contracted HCI shall submit to PhilHealth a sworn declaration that a patient is expired or lost to follow-up when filing the claim for the specific treatment phase.

21. All patients availing of the ZMORPH shall be monitored for return to productivity or community reintegration as outcomes in the next six (6) months. Reports may be subjected to monitoring and post-audit by PhilHealth.

22. All patients 50 years of age and above, who are under the 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. DESIGNATION OF THE Z BENEFITS COORDINATOR FOR EXPANDED Z MORPH

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

1. Provide guidance to Z patients by facilitating timely access to the services required for the Z Benefits. Guiding Z patients enrolled in the program aims to overcome healthcare barriers in the availment of the said benefits in order to ensure patient adherence to agreed treatment plans with the goal of achieving expected ~~good~~ 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 into the ZBITS Module of the HCI Portal the pertinent information (i.e. demographics) of all patients needing prostheses/orthoses, whether or not the patient fulfills the selections criteria for pre-authorization;

4. Enter pertinent data elements of all patients with approved Pre-authorization Checklist and Request (Annex "A") in the required fields of the ZBITS Module of the HCI Portal. These data elements shall be determined by PhilHealth, experts in prostheses/orthoses, Reference HCI and other stakeholders for purposes of quality improvement, policy research, and monitoring. Contracted HCIs are encouraged to train their respective Z Benefits coordinator/s;

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.

IV. CRITERIA FOR INCLUSION, MINIMUM STANDARDS OF CARE, AND PACKAGE RATES FOR EXPANDED ZMORPH

The overall package code for the Z benefit for Expanded ZMORPH is **Z015.** The following are the corresponding descriptions, selections criteria, frequency and rates of the package:

A. SELECTIONS CRITERIA

The following are the selections criteria:

1. Upper and Lower Limb Prostheses

a. Age ≥ 18 years old
b. At least three months post-amputation, if acquired
c. Wheelchair independent, community-ambulator with or without crutches, cane or walker
d. On physical examination: no fresh or non-healing wound, neuroma or painful residual limb, no motor strength of <4/5 and limitation of motion of upper and/or lower limbs, no incoordination or poor balance

2. Lower limb orthosis

a. Age ≥ 18 years old
b. At least three months post-onset
c. Upper limbs ≥ 4 with fair trunk control and full range of motion, if bilateral
d. Unaffected limbs ≥ 3 with fair trunk control and full range of motion, if unilateral
e. Ambulatory with assistive device
f. No fresh or non-healing wound

2.1 Ankle foot orthoses

a. Weakness or absence of dorsiflexors &/or plantarflexors, +/- grade 1-2 spasticity with full range of motion achieved passively
b. Equinovarus +/- foot rotation and +/- grade 1-2 spasticity with full range of motion achieved passively
c. Pain & Instability secondary to sensory or structural deficit in a Charcot Arthropathy

2.2 Knee ankle foot orthoses

Quadriceps MMT of <3 +/- sensory loss ,+/- instability (genu recurvatum) with hip/knee flexion contracture <20 degrees

2.3 Hip knee ankle foot orthoses

Hip, knee, ankle & foot muscles MMT <3 +/- sensory loss, +/- instability, with hip /knee flexion contracture <20 degrees

3. Spinal orthosis

a. Age ≥ 18 years old
b. Upon diagnosis &/or post-operative clearance
c. No sensory deficit over body segment of application
d. Upper and lower limb manual muscle strength of ≥ 3

3.1 Thoracolumbosacral custom molded spinal orthosis

a. Thoracolumbar (T12-L2) spinal fractures involving posterior elements
b. Primary or metastatic lesions to the thoracolumbosacral spine

3.2 Lumbosacral custom molded spinal orthosis

a. Lumbosacral fractures (L1-L3)
b. Primary or metastatic lesions to the lumbosacral spine

3.3 Cervicothoracic custom molded spinal orthosis

a. Cervical spine fractures (C3-C7) without neurologic deficit
b. Torticollis
c. Metastatic lesions without neurologic deficit

B. PACKAGE CODE AND RATES

The following are the package codes and corresponding rates per laterality:

Table 1. Package codes and rates for Expanded ZMORPH- Prostheses/orthoprostheses

Description	Package Code			Package Rate (Php) per laterality
	Right	Left	Both	
I. Prosthesis*				
A. Above knee/ knee disarticulation (AKKD)	Z0151A	Z0151B	Z0151C	75,000.00
B. Hip disarticulation (HD)	Z0152A	Z0152B	Z0152C	135,000.00
C. Below elbow (BE)	Z0153A	Z0153B	Z0153C	50,000.00
D. Above elbow (AE)	Z0154A	Z0154B	Z0144C	70,000.00
E. Van Ness Rotationplasty	Z0155A	Z0155B	Z0155C	85,000.00
II. Ortho/prostheses**				
A. Ankle foot	Z0156A	Z0156B	Z0156C	17,500.00
III. Orthoses**				
A. Knee ankle foot	Z0157A	Z0157B	Z0157C	35,000.00
B. Hip knee ankle foot	Z0158A	Z0158B	Z0158C	80,000.00

* For cases involving more than one amputation, the patient is not allowed to claim two prostheses simultaneously with the same laterality in either the upper (i.e. BE, AE) or in the lower (AKKD, HD) limb. To illustrate this, please refer to Table 5.

** For cases involving more than one amputation, the patient is not allowed to claim two orthoses simultaneously with the same laterality.

Table 2. Package codes and rates for Expanded ZMORPH- Spinal Orthoses

Description	Package Code	Package Rate (Php)
IV. Spinal		
A. Thoracolumbosacral	Z0159	40,000.00
B. Lumbosacral	Z01510	30,000.00
C. Cervicothoracic	Z01511	45,000.00

C. MINIMUM STANDARDS OF CARE

The Expanded ZMORPH shall reflect the following mandatory and other services:

Table 3. Mandatory and other services for Expanded ZMORPH

Mandatory Services	Other Services
1. Pre-prosthetic /orthotic assessment by a board certified physician of the Philippine Board of Rehabilitation Medicine	When warranted, pre-prosthetic / orthotic rehabilitation shall be prescribed by a board certified physician of the Philippine Board of Rehabilitation Medicine and implemented by a PRC licensed physical therapist or occupational therapist
2. Measurement and casting by International Society of Prosthetics & Orthotics (ISPO)/DOH Category I or II prosthetist/orthotist	
3. Prosthetic /Orthotic fabrication & check-out by ISPO/DOH Category 1 or 2	
4. Post-prosthetic/orthotic fitting prescription for six physical therapy or occupational therapy sessions by board certified physician of the Philippine Board of Rehabilitation Medicine	
5. Conduct of six physical therapy or occupational therapy sessions by PRC licensed physical therapist or occupational therapist	
6. Final discharge disposition by a board certified physician of the Philippine Board of Rehabilitation Medicine	

D. MODE OF PAYMENT AND FILING SCHEDULE

The mode of payment for Expanded ZMORPH shall be given in tranches with the corresponding amounts and filing schedule with the allowed frequency of availment as follows:

Table 4. Mode of payment and filing schedule for Expanded ZMORPH

Description	Tranche	Amount (Php)	Filing Schedule	Frequency
I. Prosthesis				
A. Above knee/ knee disarticulation	1	65,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO/DOH	Every 5 years; maximum of 2 in a lifetime
	2	10,000	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
B. Hip disarticulation	1	120,000	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Every 5 years; maximum of 2 in a lifetime
	2	15,000	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
C. Below elbow	1	40,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Every 5 years; maximum of 2 in a lifetime
	2	10,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
D. Above elbow	1	60,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Every 5 years; maximum of 2 in a lifetime
	2	10,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
E. Van Ness Rotationplasty	1	71,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Every 5 years; maximum of 2 in a lifetime
	2	14,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	

Description	Tranche	Amount (Php)	Filing Schedule	Frequency
II. Ortho/ prostheses				
A. Ankle Foot	1	13,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Every 5 years; maximum of 2 in a lifetime
	2	4,500.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
III. Orthoses				
A. Knee ankle foot	1	28,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Two in a lifetime
	2	7,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
B. Hip Knee Ankle Foot	1	70,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Two in a lifetime
	2	10,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
IV. Spinal				
A. Thoracolumbo-sacral	1	32,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Two in a lifetime
	2	8,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
B. Lumbosacral	1	22,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Once in a lifetime
	2	8,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	
C. Cervicothoracic	1	32,000.00	Within 60 calendar after Prosthetic /Orthotic fabrication & check-out by ISPO	Once in a lifetime
	2	8,000.00	Within 60 calendar days after the last physical therapy or occupational therapy sessions	

V. CLAIMS FILING & REIMBURSEMENT

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

2. All claims shall be filed by the contracted HCIs in behalf of the patients. There shall be no direct filing by members.

3. The contracted HCI shall submit a claim application per completed tranche.

4. For cases involving more than one amputation, the patient is not allowed to claim two prostheses simultaneously with the same laterality in either the upper (i.e. BE, AE) or in the lower (AKKD, HD) limb.

Table 5. Examples of cases involving two levels of amputations

Example	Decision	Explanation
(Left) AKKD and (Left) HD	Deny	Same laterality in the same level of amputation (lower level). This will involve the same prostheses in the lower limb.
(Left) AKKD and (Left) BE	Pay	Same laterality but different levels of amputation (AKKD at the lower level and BE at the upper level). Patient is ambulatory with assistive device.
(Left) AKKD and (Left) AE	Pay	Same laterality but different levels of amputation (AKKD at the lower level and AE at the upper level). Patient is ambulatory with assistive device.
(Left) AKKD and (Right) HD	Pay	Different laterality
(Left) BE and (Left) AE	Deny	Same laterality in the same level of amputation (lower level). This will involve the same prostheses in the upper limb.

5. For the initial claim application (i.e. tranche 1), the following shall be attached:
   a. Transmittal Form (Annex "H") of all claims for Expanded ZMORPH for submission to PhilHealth, per claim or per batch of claims;
   b. Original copy of the approved Pre-authorization Checklist and Request;
   c. Certified true copy of the properly accomplished ME Form;
   d. PhilHealth Benefit Eligibility Form (PBEF) printout during the pre-authorization application.

      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;

      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;

      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.

e. Properly accomplished Claim Form 2

f. Discharge Checklist of Services (Annex "C") for the corresponding tranches

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

h. Tranche Requirements Checklist (Annex "E")

6. For succeeding claims, the Transmittal Form, Claim Form 2, the Discharge Checklist Services (Annex "C"), Photocopy of Z Satisfaction Questionnaire (Annex "D") and the Tranche Requirements Checklist for the Z Benefits (Annex "E") shall be submitted

7. The Z Satisfaction Questionnaire (Annex "D") shall be administered to all Z patients prior to final discharge disposition from the contracted HCI. These are validated during field monitoring by PhilHealth and shall be used as basis of the Corporation for benefits enhancement, policy research and quality improvement purposes.

8. Rules on late filing shall apply.

9. 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 by RA 9241 and RA 10606).

VI. POLICY REVIEW

Pursuant to PhilHealth Circular No. 035-2015, a regular policy review shall be conducted in collaboration with all relevant stakeholders, experts and technical staff representatives from the Corporation.

VII. REPEALING CLAUSE

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

VIII. EFFECTIVITY

This circular shall take effect fifteen (15) days from 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.

IX. ANNEXES

The following annexes may be downloaded from the PhilHealth website: www.philhealth.gov.ph

1. Pre-authorization Checklist (Annex "A")
2. Member Empowerment Form (Annex "B")
3. Discharge Checklist for Expanded ZMORPH (Annex "C")
4. Z Satisfaction Questionnaire (Annex "D")
5. Checklist of Requirements for Reimbursement (Annex "E")

RAMON F. ARISTOZA, JR.
Acting President and CEO

Date signed: 11/21/16

Republic of the Philippines
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Case No. _____

Annex "A1 –EMORPH"

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 EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

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

QUALIFICATIONS	
a. Age ≥ 18 years old	
b. At least three months post-amputation, if acquired	
c. Wheelchair independent, community-ambulator with or without crutches, cane or walker	
d. On physical examination: no fresh or non-healing wound, neuroma or painful residual limb, no motor strength of <4/5 and limitation of motion of upper and/or lower limbs, no incoordination or poor balance	

Place a check mark (✓) on the type of prostheses to be given to the patient:

Z Benefits*	Right	Left	Both
I. Lower limb			
A. Above knee/ knee disarticulation			
B. Hip disarticulation			
C. Van Ness Rotationplasty			
II. Upper limb			
A. Below elbow			
B. Above elbow			

* For cases involving more than one amputations, the patient cannot claim for two prostheses with the same laterality in either the same limb.

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 EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

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 _____

*NBB is applicable to sponsored members, indigent, kasambahay, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.

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.

(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		
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:		

Case No. _____

Annex "A2 – EMORPH"

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 EXPANDED ZMORPH
Lower Limb Orthosis

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

	GENERAL QUALIFICATIONS	Yes
1.	Age ≥ 18 years old	
2.	At least 3 months post-onset	
3.	Upper limbs ≥ 4 with fair trunk control and full range of motion, if bilateral	
4.	Unaffected limbs ≥ 3 with fair trunk control and full range of motion, if unilateral	
5.	Ambulatory with assistive device	
6.	No fresh or non-healing wound	

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

	QUALIFICATIONS SPECIFIC TO ANKLE FOOT ORTHOSIS	Yes
1.	Weakness or absence of dorsiflexors &/or plantarflexors, +/- grade 1-2 spasticity with full range of motion achieved passively	
2.	Equinovarus +/- foot rotation and +/- grade 1-2 spasticity with full range of motion achieved passively	
3.	Pain & Instability secondary to sensory or structural deficit in a Charcot Arthropathy	

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

QUALIFICATIONS SPECIFIC TO KNEE ANKLE FOOT ORTHOSIS	Yes
Quadriceps MMT of <3 +/- sensory loss ,+/- instability (genu recurvatum) with hip/knee flexion contracture <20 degrees	

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

QUALIFICATIONS SPECIFIC TO HIP KNEE ANKLE FOOT ORTHOSIS	Yes
Hip, knee, ankle & foot muscles MMT <3 +/- sensory loss, +/- instability, with hip /knee flexion contracture <20 degrees	

Place a check mark (✓) on the type of ortheses to be given to the patient:

Z Benefits	Right	Left	Both
Ankle Foot Orthosis			
Knee Ankle Foot Orthosis			
Hip Knee Ankle Foot Orthosis			

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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Call Center (02) 441-7442 Trunkline (02) 441-7444
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PRE-AUTHORIZATION REQUEST FOR Z MORPH
Lower Limb Orthosis

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 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 _____

*NBB is applicable to sponsored members, indigent, kasambahay, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.

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		
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 "A3 – EMORPH"

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 EXPANDED ZMORPH
Spinal Orthosis

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

	General Qualifications	Yes
1.	Age ≥ 18 years old	
2.	Upon diagnosis &/or post-operative clearance	
3.	No sensory deficit over body segment of application	
4.	Upper and lower limb manual muscle strength of ≥ 3	

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

	Qualifications for Thoracolumbosacral Spinal Orthosis	Yes
1.	Thoracolumbar (T12-L2) spinal fractures involving posterior elements	
2.	Primary or metastatic lesions to the thoracolumbosacral spine	

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

	Qualifications for Lumbosacral Spinal Orthosis	Yes
1.	Lumbosacral fractures (L1-L3)	
2.	Primary or metastatic lesions to the lumbosacral spine	

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

	Qualifications for Cervicothoracic Spinal Orthosis	Yes
1.	Cervical spine fractures (C3-C7) without neurologic deficit	
2.	Torticollis	
3.	Metastatic lesions without neurologic deficit	

Tick the box corresponding to the type of spinal orthosis to be given to the patient:

- ☐ Thoracolumbosacral custom molded spinal orthosis
- ☐ Lumbosacral custom molded spinal orthosis
- ☐ Cervicothoracic custom molded spinal orthosis

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

Printed name and signature

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

MASTER DOCUMENT DC: Date: 12/1/16

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.

PRE-AUTHORIZATION REQUEST FOR Z MORPH
Spinal Orthosis

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 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 _____

*NBB is applicable to sponsored members, indigent, kasambahay, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.

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		
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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Numero ng kaso: _____
Case No.

Annex "B-ME Form"

MEMBER EMPOWERMENT FORM

Magpaalám, tumulong, at magbigay kapangyarihan
Inform, Support & Empower

Mga Panuto:
Instructions:

1. Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
   The health care provider shall explain and assist the patient in filling-up the ME form.
2. Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
   Legibly print all information provided.
3. Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka (√) ang angkop na kahon.
   For items requiring a "yes" or "no" response, tick appropriately with a check mark (√).
4. Gumamit ng karagdagang papel kung kinakailangan . Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
   Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
   The ME form shall be reproduced by the contracted health care institution (HCI) providing specialized care.
6. Tatlong kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente, ospital at PhilHealth.
   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. **Para sa mga pasyenteng gagamit ng Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, isulat ang N/A sa tala B2, B3 at D6. Para naman sa Peritoneal Dialysis (PD) First Z Benefits, isulat ang N/A para sa tala B2 at B3.**
   For patients availing of the Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH) for fitting of the external lowerlimb prosthesis, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

PANGALAN NG OSPITAL *HEALTH CARE INSTITUTION (HCI)*
ADRES NG OSPITAL *ADDRESS OF HCI*

A. Impormasyon ng Miyembro/ Pasyente
A. Member/Patient Information

PASYENTE (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
PATIENT (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG PASYENTE ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF PATIENT

MIYEMBRO (kung ang pasyente ay kalipikadong makikinabang) (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG MIYEMBRO ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF MEMBER

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

Petsa ng Kapanganakan (Buwan/Araw/Taon) *Birthday (mm/dd/yyyy)*	Edad *Age*	Kasarian *Sex*
Numero ng Telepono *Telephone Number*	Numero ng Cellphone *Mobile Number*	Email Address *Email Address*

Kategorya bilang Miyembro:
Membership Category:

☐ Empleado sa
Employed Sector
- ☐ Gobyerno
  Government
- ☐ Pribado
  Private
  - ☐ May-ari ng Kompanya / *Enterprise Owner*
  - ☐ Kasambahay / *Household Help*
  - ☐ Tagamaneho ng Pamilya/ *Family driver*

☐ *Self Employed*
- ☐ Filipinong Manggagawa sa ibang bansa
  Migrant Worker/OFW
- ☐ Informal Sector / May sariling pinagkakakitaan (Halimbawa. Negosyante, Nagmamaneho ng traysikel at taxi, mga propesyonal, artista, at iba pa)
  Informal Sector / Self-Earning Individuals (Ex. Business owner/ tricycle/ taxi drivers/ street vendors, entrepreneurs, professionals, artists, etc.)
- ☐ Filipino na may dalawang pagkamamamayan/ *Naturalized Filipino Citizen*
  Filipino with Dual Citizenship/Naturalized Filipino Citizen
- ☐ *Organized Group* ☐ *IGroup Gold*

☐ Marálitâ
Indigent (4Ps/CCT, MCCT)

☐ Inisponsuran
Sponsored
- ☐ Bayan | *LGU*
- ☐ Nakatatandang mamamayan | *Senior Citizen* (RA 10645)
- ☐ Iba pa | *Others*

☐ Habambuhay na kaanib/ Lifetime Member

MASTER DOCUMENT Date: 11/16 DC:

B. Impormasyong Klinikal *B. Clinical Information*	
1. Paglalarawan ng kondisyon ng pasyente *Description of condition*	
2. Napagkasunduang angkop na plano ng gamutan sa ospital *Applicable Treatment Plan agreed upon with healthcare provider*	
3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital *Applicable alternative Treatment Plan agreed upon with health care provider*	
C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon *C. Treatment Schedule and Follow-up Visit/s*	
1. Petsa ng unang pagkakaospital o konsultasyon [a] (buwan/araw/taon) *Date of initial admission to HCI or consult[a] (mm/dd/yyyy)* [a] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa pagkonsulta para sa rehabilitasyon ng external lower limb pre-prosthesis/ device. Para naman sa PD First, ito ay ang petsa ng konsultasyon o pagdalaw sa PD provider bago magsimula ang unang PD exchange. *[a] For ZMORPH/children with disabilities (CWDs), this refers to the consult prior to the provision of the device and/or rehabilitation. 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. Petsa ng susunod na pagpapa-ospital o konsultasyon[b] (buwan/araw/taon) *Date/s of succeeding admission to HCI or consult[b] (mm/dd/yyyy)* [b] Para sa ZMORPH/ mga batang may kapansanan, ito ay petsa ng paglalapat at pagsasayos ng device. Para naman sa PD First, ito ay ang kasunod na pagbisita sa PD Provider. *[b] For ZMORPH/CWDS, this refers to the measurement, fitting and adjustments of the device. For the PD First, this refers to the next visit to the PD Provider.*	
3. Petsa ng kasunod na pagbisita [c] (buwan/araw/taon) *Date/s of follow-up visit/s[c] (mm/dd/yyyy)* [c] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa rehabilitasyon ng external lower limb post-prosthesis. *[c] For ZMORPH/CWD, this refers to the external lower limb post-prosthesis rehabilitation consult.*	

D. Edukasyon ng Miyembro *D. Member Education*		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark(√) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. *My health care provider explained the nature of my condition/ disability.*		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon [d] *My health care provider explained the treatment options/ intervention[d].* [d] Para sa ZMORPH, ito ay ukol sa pangangailangan ng pagbibigay at rehabilitasyon para sa pre at post-device. *[d]For ZMORPH, this refers to the need for pre- and post-device provision and rehabilitation.*		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/ masamang epekto ng gamutan/ interbensyon. *The possible side effects/ adverse effects of treatment/ intervention were explained to me.*		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon. *My health care provider explained the mandatory services and other services required for the treatment of my condition/ intervention.*		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. *I am satisfied with the explanation given to me by my health care provider*		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. *I have been fully informed that I will be cared for by all the pertinent medical and allied 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. Ipinaliwanag ng kinatawan ng ospital ang kahalagahan ng pagsunod sa panukalang gamutan/interbensyon. Kasama rito ang pagkompleto ng gamutan/interbensyon sa unang ospital kung saan nasimulan ang aking gamutan/interbensyon. *My health care provider explained the importance of adhering to my treatment plan/ intervention. This includes completing the course of treatment/ intervention in the contracted HCI where my treatment/ intervention was initiated.* Paalala: Ang hindi pagsunod ng pasyente sa napagkasunduang gamutan/interbensyon sa ospital ay maaaring magresulta sa hindi pagbabayad ng mga kasunod na claims at hindi dapat itong ipasa bilang case rates. *Note: Non-adherence of the patient to the agreed treatment plan/ intervention in the HCI may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		

Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark(√) opposite appropriate answer or N.A if not applicable.*	OO YES	HINDI NO
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/s of my follow-up visit/s.*		
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) *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. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. *I have been furnished by my health care provider with a list of other contracted HCIs for the specialized care of my condition.*		
11. Nabigyan ako ng sapat na kaalaman hinggil sa benepisyo at tuntunin ng PhilHealth sa pagpapa-miyembro at paggamit ng benepisyong naaayon sa Z benefits: I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits: a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan. *I fulfill all selections criteria for my condition/ disability.*		
b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB) *The "no balance billing" (NBB) policy was explained to me.* Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) *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.*		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e. ***For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.*** c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. *I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses*		

d. Sakaling ako ay pumili ng pribadong doktor o kaya ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan) *In case I choose a private doctor or I choose to upgrade my room accomodation, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)* e. Tinatalikdan ko na ang aking pribilehiyo bilang pasyente na NBB at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth *I waive my privilege as an NBB patient and I am willing to pay on top of my PhilHealth benefits*		
Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang ***The following are applicable to formal and informal economy and their qualified dependents*** f. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth. *I understand that there may be an additional payment on top of my PhilHealth benefits.*		
12. Limang (5) araw lamang ang babawasan mula sa 45 araw na palugit sa benepisyo sa isang taon para sa buong gamutan sa ilalim ng Z benefits. *Only five (5) days shall be deducted from the 45 confinement days benefit limit per year for the duration of my treatment/ intervention under the Z Benefits.*		

E. Tungkulin at Responsabilidad ng Miyembro *E. Member Roles and Responsibilities*		
Lagyan ng (√) ang angkop na sagot o NA kung hindi nauukol *Put a (√) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. *I understand that I am responsible for adhering to my treatment schedule.*		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang Z benefits. *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. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong Z benefit package. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng Z benefits. *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. Pangalan, Lagda, Thumb Print at Petsa *F. Printed Name, Signature, Thumb Print and Date*		
Pangalan at Lagda ng pasyente:* *Printed name and signature of patient** *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	**Thumb Print** (kung hindi makakasulat ang pasyente) *(if patient is unable to write)*	**Petsa** (buwan/ araw/ taon)
Pangalan at lagda ng nangangalagang Doktor: *Printed name and signature of Attending Doctor*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Mga Saksi: *Witnesses:*		
Pangalan at lagda ng kinatawan ng ospital: *Printed name and signature of HCI staff member*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan *Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

G. Detalye ng Tagapag-ugnay ng PhilHealth para sa Z benefits *G. PhilHealth Z Coordinator Contact Details*		
Pangalan ng Tagapag-ugnay ng PhilHealth para sa Z benefits na nakatalaga sa ospital *Name of PhilHealth Z Coordinator assigned at the HCI*		
Numero ng Telepono *Telephone number*	Numero ng CellPhone *Mobile number*	Email Address

H. Numerong maaaring tawagan sa PhilHealth *H. PhilHealth Contact Details*
Opisinang Panrehiyon ng PhilHealth _____ *PhilHealth Regional Office No.* Numero ng telepono _____ *Hotline Nos.*

Revised as of November 2016 Page 7 of 8 of Annex B – ME Form

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I. Pahintulot sa pagsusuri sa talaan ng pasyente *I. Consent to access patient record*	J. Pahintulot na mailagay ang *medical data* sa Z benefit information and tracking system ZBITS) *J. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)*
Ako ay pumapayag na suriin ng PhilHealth ang aking talaang medikal upang mapatunayan ang katotohanan ng Z-claim *I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the Z-claim*	Ako ay pumapayag na mailagay ang aking impormasyong medikal sa ZBITS na kailangan sa Z benefits. Pinahihintulutan ko din ang PhilHealth na maipaalam ang aking personal na impormasyong pangkalusugan sa mga kinontratang ospital. *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*

Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng Z benefits ng PhilHealth.

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.

Buong pangalan at lagda ng pasyente* *Printed name and signature of patient** * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/ dd/ yyyy)*
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative*		Petsa (buwan/araw/taon) *Date (mm/ dd/ yyyy)*

Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon)
Relationship of representative to patient (tick appropriate box)

☐ asawa *spouse* ☐ magulang *parent* ☐ anak *child* ☐ kapatid *next of kin* ☐ tagapag-alaga *guardian*

MASTER DOCUMENT DC: Date: 12/1/16

Republic of the Philippines
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Case No. _____

Annex "C1.1 – EMORPH"

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Prosthesis

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 (✓) or NA if not applicable

CRITERIA	Yes
1. External lower limb prosthesis provided is as prescribed with appropriate pressure tolerant and sensitive areas, well-fitting socket, good suspension, proper alignment and stable prosthetic foot while standing and walking	
2. The lower limb stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of prosthetic weight bearing while standing and/or walking	
3. Prosthesis user ambulates within expected gait parameters and steps up and down five (5) steps with assistive device	
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning, doffing, cleaning, precautions and falling techniques	

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)

MASTER DOCUMENT Date: 12/1/16 DC: ____

Republic of the Philippines
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Case No. _____

Annex "C1.2 – EMORPH"

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Upper Limb Prosthesis

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 (✓) or NA if not applicable

CRITERIA	Yes
1. External upper limb prosthesis provided is as prescribed with properly aligned and fitted socket, suspension, cable systems and terminal device	
2. The upper limb stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of use	
3. Upper limb prosthesis provides at the minimum body image completion and maximally assisted upper extremity gross motions	
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning, doffing, cleaning, precautions and falling techniques	

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 "C1.3 – EMORPH"

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Orthosis

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 (✓) or NA if not applicable

CRITERIA	Yes
1. External lower limb orthosis provided is as prescribed with appropriate alignment and fit	
2. The lower limb is free of blisters, vascular compromise, pain, hypersensitivity after 30 minutes of orthosis weight-bearing while standing and/or walking	
3. Lower limb orthosis allows safe ambulation with or without assistive device	
4. Orthosis user possesses competent skill and knowledge regarding donning, doffing, cleaning, precautions and falling techniques	

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)

MASTER DOCUMENT Date: 12/1/16 DC:

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Annex "C1.4 – EMORPH"

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Spinal Orthosis

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 (✓) or NA if not applicable

CRITERIA	Yes
1. Spinal orthosis provided is as prescribed with proper alignment and appropriate fit	
2. The [body segment] trunk/torso is free of blisters, vascular compromise, pain, hypersensitivity after 30 minutes of use	
3. Spinal orthosis user possesses competent skill and knowledge regarding donning, doffing, cleaning, precautions and falling techniques	

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)

MASTER DOCUMENT DC: ___ Date: 12/1/16

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Case No. _____

Annex "C2 – EMORPH"

DISCHARGE CHECKLIST FOR EXPANDED Z MORPH
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 check mark (✓) on the type of prostheses or orthosis to be given to the patient:

Z Benefits		Right	Left	Both
I. Lower limb prosthesis	1. Above knee/ knee disarticulation			
	2. Hip disarticulation			
	3. Van Ness Rotationplasty			
II. Upper limb prosthesis	4. Below elbow			
	5. Above elbow			
III. Lower limb orthosis	6. Ankle foot			
	7. Knee ankle foot			
	8. Hip knee ankle foot			
IV. Spinal orthosis	☐ Thoracolumbosacral	☐ Lumbosacral	☐ Cervicothoracic	

Rehabilitation Sessions	Dates Performed					
Physical therapy OR						
Occupational therapy						

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)

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
   - ☐ ZMORPH/Expanded ZMORPH
   - ☐ Orthopedic implants
   - ☐ PD First Z benefits
   - ☐ Colorectal cancer
   - ☐ Prevention of preterm delivery
   - ☐ Premature and small newborn

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!

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Case No. _____

Annex "E1 – EMORPH"

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)
Expanded ZMORPH

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E1-EMORPH)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-EMORPH)	
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 Expanded ZMORPH (Tranche 1) (Annex C1-EMORPH)	
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 "E2 – EMORPH"

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)
Expanded ZMORPH

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E2-EMORPH)	
3. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-EMORPH)	
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 Expanded ZMORPH (Tranche 2) (Annex C2-EMORPH)	
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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