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

Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

PHILHEALTH CIRCULAR
No. 2017 - 0016

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

SUBJECT : Enhanced package rate for the Z Benefits for Standard Risk Acute Lymphocytic (Lymphoblastic) Leukemia

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I. RATIONALE

The package rate for the Z Benefits for standard risk acute lymphocytic (lymphoblastic) leukemia is adjusted accordingly as approved through PhilHealth Board Resolution No. 2177, s. 2016.

II. GUIDELINES

The rules for benefits availment and claims reimbursement shall follow PhilHealth Circular No. 2015-035 (The Guiding Principles of the Z Benefits). Submission of pre-authorization requests by contracted healthcare institutions (HCI), however, shall be prior to the end of the induction phase. The example below illustrates the application of this provision.

Table 1. Example illustrating the date of submission of pre-authorization vis a vis the date of discharge reflected in the CF2 and the reimbursement decision

Date of submission of pre-authorization	End of induction phase (Date reflected in CF2 is date of discharge)	Reimbursement decision
May 15, 2017	June 15, 2017	PAY
May 16, 2017	May 15, 2017	DENY

III. PACKAGE RATE

The package rate for the Z Benefits for standard risk acute lymphocytic (lymphoblastic) leukemia shall be five hundred thousand pesos (Php 500,000) for the complete course of treatment for three (3) years. This shall be divided into three (3) tranches according to the following scheme:

Table 2. Package code, mode of payment, amount per tranche and filing schedule

Package code	Mode of payment	Amount (Php)	Filing schedule
Z0011	Tranche 1	300, 000	Within 60 days upon discharge after the 1st induction phase
Z0012	Tranche 2	125, 000	Within 60 days after the 3rd maintenance cycle
Z0013	Tranche 3	75, 000	Within 60 days after the 7th maintenance cycle

A separate issuance shall be disseminated once the Department of Health (DOH) has developed the mechanism for the provision of free cancer medicines for public health care institution that are contracted to provide the services for the Z Benefits for acute lymphocytic (lymphoblastic) leukemia.

IV. REPEALING CLAUSE

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

V. EFFECTIVITY

This circular shall take effect for all approved pre-authorizations 15 days after publication in the Official Gazette or in a newspaper of national circulation and shall be deposited thereafter at the Office of the National Administrative Register, University of the Philippines Law Center.

VI. ANNEXES

Annex "A"	Pre-authorization checklist and request
Annex "B"	Membership Empowerment Form (Filipino version)
Annex "C"	Checklist of Mandatory Services (Tranche 1, 2, and 3)
Annex "D"	Z Satisfaction Questionnaire
Annex "E"	Checklist of Requirements for Reimbursement (Tranche 1, 2, and 3)

Please be guided accordingly.

DR. CELESTINA MA. JUDE P. DELA SERNA
Interim/OIC President and CEO
Date signed:

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Case No. _____

Annex "A – ALL"

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

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

PRE-AUTHORIZATION CHECKLIST
Acute Lymphocytic/Lymphoblastic Leukemia
Standard Risk

Place a check mark (✓)

QUALIFICATION	YES
Age 1 to 10 years and 364 days	

Conforme by Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING PHYSICIAN

Place a check mark (✓)

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

* L3 morphology is excluded

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Place a check mark (✓)

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

Certified correct by Attending Physician:

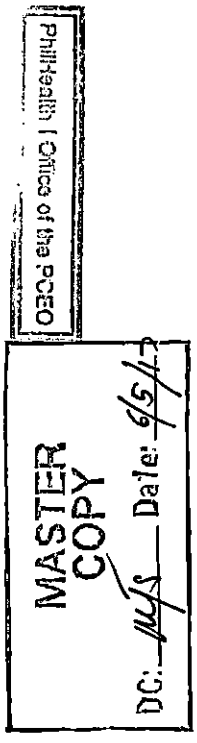
Printed name and signature

PhilHealth Accreditation No. - - -

Note:

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

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.



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

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ in _____
(NAME OF PATIENT) (NAME OF HCI)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

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

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

MASTER COPY Date: 6/5/17 DC: MJS

Conforme by:

(Printed name and signature)
Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION		
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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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

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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 NA 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.*

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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*

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Case No. _____

Annex "C1 – ALL"

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

Tranche 1

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐
DATE OF END OF INDUCTION PHASE (mm/dd/yyyy)

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

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

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

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

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

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

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

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Annex "C2 – ALL"

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

Tranche 2

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
DATE OF END OF 3RD MAINTENANCE CYCLE (mm/dd/yyyy)

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

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

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

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

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

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Annex "C3 – ALL"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
After 7th Maintenance Cycle

Tranche 3

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
DATE OF END OF 7TH MAINTENANCE CYCLE

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

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

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

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

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

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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
   - ☐ Preterm and small baby

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

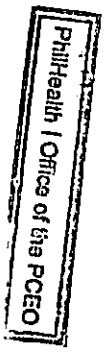
7. In your opinion, by how much has your HCI expenses been lessened by availing of the Z benefit package?
   - ☐ less than half
   - ☐ by half
   - ☐ more than half
   - ☐ don't know

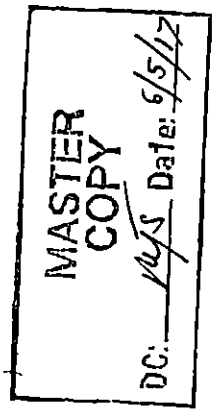
8. Overall patient satisfaction (PS mark) is:
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

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

   _____
   _____
   _____

Thank you. Your feedback is important to us!





Date accomplished: (mm/dd/yyyy)

_____

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Annex "E1 – ALL"

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

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

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

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

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Annex "E2 – ALL"

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

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

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

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

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Annex "E3 – ALL"

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

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 3)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
After 7th Maintenance Cycle

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

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	Date signed (mm/dd/yyyy)
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As of May 2017