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PHILHEALTH CIRCULARY

TO

ALL CONTRACTED HEALTHCARE PROVIDERS FOR THE

Z BENEFITS AND ALL OTHERS CONCERNED

SUBJECT

The Guiding Principles of the Z Benefits (Revision 1)

#### I. RATIONALE

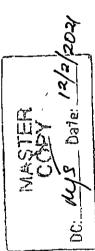
The Philippine Health Insurance Corporation (PhilHealth) started implementing the Z Benefits on June 21, 2012, per PhilHealth Board Resolution (PBR) No. 1629 s. 2012. These benefits focus on providing financial risk protection against illnesses perceived as medically and economically catastrophic affecting many Filipinos, especially those belonging to the marginalized sector of society. With the Z Benefits, every patient enrolled in the program is provided quality care that is at par with current standards of practice.

Contracted healthcare providers (HCPs) for the Z Benefits provide state of the art treatment that increase the survival rate from catastrophic diseases. For instance, in most solid cancers, surgery by trained surgeons is the primary mode of treatment and can be curative in early stages; chemotherapy by medical oncologists/pediatric oncologists is the primary mode of treatment before and after surgery for these solid cancers; radiotherapy by trained radiation oncologists is usually used for control and palliative care of cancer. All of these emphasize the multidisciplinary-interdisciplinary approach to patient care, with each discipline respecting the role and expertise of the other.

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

PhilHealth, the contracted HCPs and all key stakeholders are partners in the development, implementation, and enhancement of the Z Benefits that aim to achieve better health outcomes. With the help of the Z Benefits, patients are ushered back to society as productive citizens that contribute to the economic growth of the country.

PhilHealth developed these guiding principles to demonstrate the Corporation's commitment to continuous quality improvement through the enhancement of service delivery and the improvement in the overall implementation of the Z Benefits. This Circular is a result of several policy reviews conducted with key stakeholders. The provisions in this Circular capture the pertinent inputs from experts, representatives from the PhilHealth Regional Offices (PROs), other PhilHealth offices, and most importantly, from patients who are members of the National Health Insurance Program.





### II. OBJECTIVE

### A. General Objective

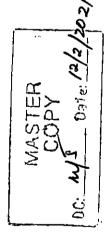
This PhilHealth Circular establishes the guiding principles of the Z Benefits and defines the policies and procedures in the delivery of quality health services to all members.

### B. Specific Objectives

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

### III. SCOPE

This Circular shall apply to all HCPs that are contracted to provide the services under the Z Benefits, and other relevant stakeholders involved in the implementation of the said benefit packages.





#### IV. DEFINITION OF TERMS

- A. Contracted HCPs a PhilHealth-accredited health facility that enters into a contract with PhilHealth for the provision of specialized care.
- B. Co-payment a pre-determined amount agreed upon by the contracted healthcare providers and PhilHealth that will be charged to patients covering the share for amenities, or any additional or upgrade of services per cycle of care of the Z Benefits. Co-payments shall have a fixed limit or cap that is not to exceed the corresponding rate of the Z Benefit package being availed of. These shall be stipulated in the individual contracts of the healthcare providers.
- C. Conditional/Other services—additional services that may be necessary to provide quality care based on clinical protocols/guidelines/pathways accepted by the Corporation that are different from the mandatory services and may be given only when indicated or as necessary.
- D. Cycle of care for the Z Benefits A range of health services and care settings that includes assessment, diagnosis, treatment, management, and rehabilitation of a patient suffering from a disease, injury, or disability.
- E. Lost to follow up —a term used to characterize a patient who has not returned to or followed-up at a health facility as advised. The specific definition varies across the Z benefit packages.
- F. Mandatory services essential services that contracted HCPs are obliged to provide based on clinical evidence and/or expert consensus as approved by the Corporation.
- G. Member Empowerment (ME) Form a document that reflects the following: that the patient is informed of their Z Benefit package, treatment choices and options, treatment schedule and follow-ups, member roles and responsibilities, member education, and counseling, and other pertinent courses of action. It is jointly signed by the beneficiary or his/her guardian or representative and the attending healthcare provider in-charge upon diagnosis.
- H. Multidisciplinary Interdisciplinary Team (MDT) Approach an approach to patient care involving team members from different professional backgrounds or work disciplines, with each member providing specific services while working collaboratively together towards the goal of providing the best care to the patient.
- I. **Pre-authorization** an approval process of PhilHealth that gives the contracted HCP the information that the patient has passed the eligibility and minimum clinical selections criteria required for the availment of the Z Benefits.
- J. Quality care The extent to which health care services provided to patients improve or achieve desired health outcomes. To achieve this, health care must comprise all mandatory and other services required to produce the desired health outcome, following a multidisciplinary-interdisciplinary team approach in the delivery of patient care.
- **K.** Reference HCP is a contracted HCP (as defined) where, in addition, shall provide technical and administrative services, such as but not limited to, the creation and maintenance of a patient registry hub, costing and procurement of agreed mandatory services, setting standards of care and capacity building of prospective contracted HCPs.

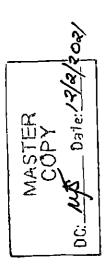


- L. Referral partner/facility any partner/facility with which a contracted HCP has a Memorandum of Agreement (MOA), as approved by the Corporation, to provide services for the continuity of care.
- M. Z Benefits benefit packages that focus on providing relevant financial risk protection against illnesses perceived as medically and economically catastrophic.
- N. Z Benefits Information and Tracking System (ZBITS) electronic patient information, monitoring, and tracking system for the Z Benefits that intends to ensure the timely provision of service to Phil-Health members.

### V. POLICY STATEMENTS

# A. ESTABLISHING THE Z BENEFITS INFORMATION AND TRACKING SYSTEM (ZBITS)

- 1. The ZBITS is the information tracking system that shall be developed by the Corporation, in collaboration with relevant stakeholders and experts, that aims to track all Z Benefits patients in contracted HCPs from diagnosis up to improvement, death or lost to follow-up, and during the referral of patients to other contracted HCPs;
- 2. The ZBITS aims to facilitate the following:
  - a. Generation of routine reports, such as but not limited to, benefits utilization, benefits payment, support value, and *co-payment*;
  - b. Monitoring the provision of the minimum standards of care (or mandatory services) and other requirements relevant to the implementation of the Z Benefits;
  - c. Generation of relevant data which may be useful for policy research and benefits enhancement, actuarial study, planning, and marketing, among others;
  - d. Determination of clinical outcomes such as survival, morbidity and mortality rates based on local data gathered from contracted HCPs and other outcomes of care that are pertinent to the Corporation, such as patient satisfaction, among others;
  - e. Other undertakings in the improvement and future implementation of the Z Benefits.
- 3. The modules for the ZBITS shall be included in the *Health Care Institution* (HCI) Portal. Thus, all contracted *HCPs* are required to have the HCI Portal installed in their facility;
- 4. The Reference HCPs shall provide PhilHealth the minimum data elements required for patient tracking that are identified to have importance for policy research, benefits enhancement, quality improvement and other undertakings such as the determination of clinical outcomes of care and other factors related to the quality of service provision in all contracted HCPs for the Z Benefits;





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- 5. Once the ZBITS is developed, the data elements identified by the reference *HCPs* shall be included in the ZBITS Module of the HCI Portal;
- 6. The HCP shall designate authorized personnel to access the ZBITS module based on the guidelines set by the Corporation.

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

#### B. DESIGNATION OF THE Z BENEFITS COORDINATOR

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

- 1. Guide and navigate Z patients by facilitating timely access to the services required for the Z Benefits. Guiding Z patients enrolled in the program aims to overcome health care barriers in the availment of the said benefits to ensure patient adherence to agreed treatment plans with the goal of achieving good clinical outcomes and ultimate patient satisfaction;
- 2. Coordinate with PhilHealth on matters pertinent to the Z Benefits availment of candidate patients, such as filling out of forms and assessing eligibility requirements before pre-authorization; and provide feedback and other inputs required by PhilHealth;
- 3. Encode pertinent clinical information and other data (e.g. demographics, etc.) of all patients diagnosed with the illness/condition covered by the Z Benefits, whether or not the patient fulfills the selections criteria for pre-authorization;
- 4. For patients who fulfilled the selections criteria and with approved Preauthorization Checklist and Request (Annex "A"), the Z Benefits Coordinator shall encode all other pertinent data elements;
- 5. Other duties and responsibilities that may be assigned by the contracted HCP such as ensuring completeness and accuracy of all attachments needed for preauthorization, claims filing and reimbursement, that shall facilitate the implementation of the Z Benefits;
- 6. The Z Benefits coordinator may handle more than one Z Benefit package provided that this will not compromise the performance of functions and the quality of services rendered to patients.

## C. GENERAL RULES FOR AVAILING OF THE Z BENEFIT PACKAGES

1. All eligible PhilHealth members are qualified to avail of the Z Benefit packages in accordance with existing guidelines on granting immediate eligibility to members.

The eligibility of the member is determined upon application for pre-authorization of the patient availing of the Z Benefits.



Patients who are not yet registered in PhilHealth shall complete member registration before they apply for pre-authorization.

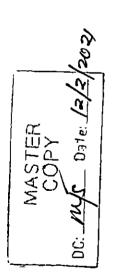
All contracted HCPs should remind these patients to update their member profiles and premium contributions, as applicable, to ensure continuity of care under the Z Benefits.

- 2. The membership category of the patient that was declared upon approval of the pre-authorization request shall be followed throughout the availment of the benefit packages, as applicable:
  - Example 1: Acute lymphocytic leukemia. The membership category upon approval of the preauthorization request shall apply for the three years that the benefit package will be availed of by the member.
  - Example 2: Peritoneal dialysis (PD) First. The membership category upon approval of the preauthorization request shall apply for the whole calendar year.
  - Example 3: Children with disabilities. The membership category upon approval of the preauthorization request shall apply for one cycle of care.
- 3. The PhilHealth Benefit Eligibility Form (PBEF) shall be the primary proof of benefit eligibility. A PBEF with a "YES" indication is sufficient to mean that the patient is eligible. Submission of other documents, such as Member Data Record (MDR) and PhilHealth Claim Form 1 (CF1), shall NO longer be required;
- 4. A NO indication on the PBEF means the member shall present MDR, Proof of Contributions or duly accomplished CF1;
- 5. Co-payment shall be fully discussed with the patients to inform them of the possible additional charges covering the share for amenities, or any additional or upgrade of services of the Z Benefits;
- 6. The co-payment for the Z Benefits, not exceeding the rate of each benefit package, shall be reflected in the individual contracts of contracted HCPs.

#### D. RULES ON PRE-AUTHORIZATION

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

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





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- 2. The approved Pre-authorization Checklist and Request shall have a validity period per Z Benefit package. All contracted HCPs are responsible for tracking the validity of their approved pre-authorizations. Contracted HCPs shall submit new pre-authorization checklists and requests prior to the expiration of the validity of any of their approved pre-authorizations if needed.
- 3. Once the member has complied with the clinical/selections criteria for availing of the benefit packages, the contracted HCP shall proceed with the process of seeking approval for pre-authorization. The pre-authorization process involves the following steps:
  - a. The contracted HCP must completely accomplish all forms required for preauthorization before the submission of the Pre-authorization Checklist and Request;
  - b. While the submission of the Pre-authorization Checklist and Request is not yet fully automated, an original copy of this Checklist and Request, along with a photocopy of the properly accomplished ME Form (Annex "B") shall be manually submitted to the Local Health Insurance Office (LHIO) or the branch of PhilHealth Regional Offices (PROs) with jurisdiction over the contracted HCPs. The said documents may also be scanned and emailed to their respective PROs for approval;

Once the ZBITS module for pre-authorization is *functional*, the contracted *HCP* shall submit the Pre-authorization Checklist and Request *and the ME Form* through the HCI Portal;

- c. The PhilHealth Regional BAS Head or authorized representative shall release to the contracted HCP the approved/disapproved Pre-authorization Checklist and Request within a maximum of seven (7) working days from the receipt of the pre-authorization application;
- d. If the application for pre-authorization is for an emergency case, the rules for the submission of the accomplished Pre-authorization Checklist and Request by a contracted HCP shall be reflected in their respective issuance;
- e. If the deadline for submission of the Pre-authorization Checklist and Request falls on a weekend or a holiday, the contracted *HCP* shall comply with *the manual* submission of requirements on the first working day after the weekend or holiday.

For electronic submissions of pre-authorization checklists and requests, PhilHealth shall view and issue approval/disapproval on the first working day after the weekend or holiday.

- f. If the delay in the submission of the Pre-authorization Checklist and Request is due to natural calamities or other fortuitous events, the contracted *HCP* shall be accorded an *extended* period of submission;
- g. The validities of all approved Pre-authorization Checklists and Requests are summarized in Annex "Q";
- h. Laboratory results shall not be required as attachments to the Pre-authorization Checklist and Request. *Instead, these* should be attached in the patient's chart and should be available during the monitoring and evaluation of the Z Benefits implementation;



i. An approved Pre-authorization Checklist and Request guarantees eligibility to the Z Benefit Package, provided, that the patient complied with the selection criteria.

#### E. FILING OF CLAIMS FOR THE Z BENEFITS

1. After the receipt of the approved Pre-authorization Checklist and Request and before filing a claim for reimbursement, the contracted HCP must render all the mandatory services (Annex "J") and other services utilizing a multidisciplinary-interdisciplinary approach to patient care as prescribed in the specific issuance.

The contracted HCP should ensure representation of each specialty required in the MDT as enumerated in the standards for contracting HCPs for the respective benefit packages;

- 2. To file a claim for reimbursement, the contracted HCP shall submit the following to PhilHealth:
  - a. Transmittal Form (Annex "H") of claims for the Z Benefit Package to be used by the contracted HCP per claim or per batch of claims;
  - b. While the submission is not yet fully automated, a photocopy of the approved Pre-authorization Checklist and Request signed by the patient, parent or guardian, and the healthcare providers as required by the respective benefit packages, for the first tranche;

For electronic submission of pre-authorizations, the original copy of the pre-authorization signed by the health care provider and the patient or patient representative shall be presented to PhilHealth. PhilHealth, on the other hand, shall only retain the photocopy or electronic copy of the approved Pre-authorization Checklist and Request;

c. While the submission is not yet fully automated, a photocopy of the properly accomplished ME Form for the first tranche;

ME Forms are accomplished in duplicate. The contracted HCP shall provide one original copy of the properly accomplished ME Form to the patient while the other copy should be attached to the patient's chart as a permanent record;

- d. PhilHealth Benefit Eligibility Form (PBEF) printout attached as proof of eligibility during the pre-authorization process;
- e. Properly accomplished PhilHealth CF2 for all tranches;

The Health Finance Policy Sector (HFPS) shall take charge of monitoring compliance to the contract between the contracted HCP and PhilHealth in terms of the co-payment of Z Benefit patients;

f. Original or certified true copy (CTC) of the Statement of Account (SOA)

The SOA shall be bear the signatures of the member or patient, or his/her representative, and of the authorized signatory of the billing section of the contracted HCP confirming that the information in the SOA are true and correct.

The co-payment declared in CF2 should match the co-payment in the SOA submitted for the specific tranche.

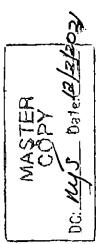




- g. Checklist of Mandatory and Other Services (Annex "C") for the corresponding tranches of the availed Z Benefit package;
- h. While the submission is not yet fully automated, photocopy of the completely accomplished Z Satisfaction Questionnaire (Annex "D").
- i. Corresponding Checklist of Requirements for Reimbursements (Annex "E");
- j. Photocopy of the operative record for surgical procedures for verification, validation and audit purposes;
- k. Photocopy of the completely accomplished Breast Cancer Medical Records Summary Form (Annex "O") for the second tranche of the Z Benefits for breast cancer;
- 3. The contracted HCPs shall file claims according to existing policies of PhilHealth;
- 4. Rules on late filing shall apply;
- 5. If the delay in the filing of claims is due to natural calamities or other fortuitous events, the existing guidelines of the Corporation on the provisions of special privileges to those affected by fortuitous events shall apply;
- 6. There shall be NO direct filing by members.

#### F. EVALUATION OF CLAIMS FOR THE Z BENEFITS

- 1. A filed claim shall undergo review for the completeness of all forms submitted. The signatures of attending PhilHealth-accredited doctors, attesting that all the mandatory services were provided to the patient, are required.
  - a. Only doctors who performed the procedures, as reflected in the operating record and anesthesia records, should sign the CF2;
  - b. All doctors providing services to Z beneficiaries should be accredited unless the doctor is a trainee;
- 2. The checklist of the mandatory and other services (Annex "C") per Z Benefit Package must be attached to the claims application;
- 3. The Policy on Return to Sender (RTS) shall not apply for the Z Benefit Packages. It is the contracted HCP's responsibility to ensure that all documents are completely filled out and in order, before submission to PhilHealth. The PROs and LHIOs have the prerogative not to accept incomplete documents. However, they should directly coordinate with the contracted HCPs regarding the deficiencies in the documents submitted. Once the documents are complete, contracted HCPs can submit these to PhilHealth for payment of claims within the required filing schedule;
- 4. All claims shall be processed by PhilHealth within 30 working days from the receipt of claims application; provided, that all requirements are submitted by the contracted





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

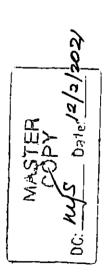
- 5. Claims shall be denied payment in the following instances:
  - a. If a mandatory service was not provided by the contracted HCP;
  - b. If the required signatures in the forms are missing;
  - Incompletely filled-out forms;
  - d. While submission is not yet fully automated, incomplete attachments, such as a photocopy of the approved Pre-authorization Checklist and Request, ME Form, Z Satisfaction Questionnaire (except for the PD First Z Benefits), operative record, and other forms required under the Z Benefit packages;
  - e. Late filing.
- 6. The contracted HCP may apply for a motion for reconsideration (MR) for all denied Z Benefit claims based on existing PhilHealth policies.

#### G. PAYMENT OF CLAIMS FOR THE Z BENEFITS

- 1. For Tranche 1, only claims with approved Pre-authorization Checklist and Request shall be processed and paid accordingly. Claims for succeeding tranches based on the order of tranche payment shall be paid (Annex "R"); provided, that the preceding tranche payments were made except for specific cases indicated in the respective issuances;
- 2. All claims shall only be paid to the contracted HCP;
- 3. In the event of a death of a patient during the course of treatment for conditions that require continuing mandatory services, such as those for chemotherapy, radiation therapy, rehabilitation or provision of PD solutions or other services under the Z Benefits, OR if a patient is declared "lost to follow-up," (Annex "S") the contracted HCP may still file claims for the payment of specific tranches for services rendered to the patient. For these instances, the HCP should submit a notarized sworn declaration for "lost to follow-up" patients, OR photocopy of the death certificate or a notarized sworn declaration issued by any of the following for expired patients:
  - a. Local civil registry
  - b. Local Government Units' Social Welfare and Development Service
  - c. Philippine National Police (PNP)
  - d. Armed Forces of the Philippines (AFP)

In instances that patients were declared "lost to follow-up" by the contracted HCP, yet were provided services under the Z Benefits in other HCPs, claims for the succeeding tranche payments for the particular Z package shall be denied;

All contracted HCPs shall submit a monthly report of expired Z patients to the Membership Section of their respective PhilHealth Regional Offices for appropriate tagging;



Claims reimbursement of expired or deceased patients that constitute a violation of the provisions of the Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and 10606) shall be validated without prejudice to the filing of appropriate legal action.

#### H. MONITORING OF THE Z BENEFITS

#### 1. Utilization and Compliance

PhilHealth shall monitor the implementation of the Z Benefit packages. This may include the field monitoring of specific Z packages provided by contracted HCPs. The method and its corresponding tools and consent forms (Annex "L") were developed for purposes including benefits monitoring, benefits enhancement, policy research, and continuous quality improvement.

The performance indicators and measures to monitor compliance with the policies of the Z Benefits of all contracted HCPs shall be established in collaboration with relevant stakeholders and experts. These shall be incorporated into the relevant monitoring policies of the Corporation.

### 2. Policy Review

- a. A regular policy review of the Z Benefits shall be conducted. The Benefits Development and Research Department (BDRD) of the HFPS of the Corporation, in collaboration with all relevant stakeholders, experts, and representatives from the PROs, shall take the lead in the policy review process. The methodology (Annex "T") for the initial policy review of the Z Benefits has been established. Improvements to the methodology of the policy review shall be made as necessary based on the future thrust and directions of the Corporation. The results of the review shall guide policy decisions regarding benefits enhancements, rates adjustments, and future directions pertinent to the Z Benefits.
- b. Contracted HCPs may provide PhilHealth with the pertinent data of complicated cases which consequently needed the provision of additional services other than those included in the specific Z benefit packages. Contracted HCPs shall use the List of Additional Services (Annex "P") when transmitting relevant data of these cases to PhilHealth. Data from this form shall be used for policy research and benefits enhancement. This form shall be submitted to the BDRD and a copy thereof shall be provided to the PhilHealth Regional Office concerned. The contracted HCP shall also be requested to provide a copy of the complete record of the case for validation purposes.

### I. MARKETING AND PROMOTION

In order to educate the general public and increase their awareness of Z Benefits and to promote informed decision-making and participation among patients, bealthcare professionals, healthcare providers, and other stakeholders, marketing and promotional activities shall be undertaken following the integrated marketing and communication plan of PhilHealth.





#### CONTRACTING HCPs AS PROVIDERS FOR THE Z BENEFITS

With the mandate of PhilHealth to provide financial risk protection against catastrophic illnesses and to pay for quality health care services, the Corporation has the prerogative to negotiate and enter into contracts with healthcare providers and professionals, among others, regarding the pricing and implementation of programs that are pertinent to the delivery of quality health care services on behalf of its members.

It was the original intent of the Z Benefits for PhilHealth to contract only tertiary government HCPs for the implementation of the catastrophic benefits for the marginalized sectors of society to access health services that meet the minimum standards of care. Such services shall be provided by HCPs in the private sector without imposing out of pocket payments on patients. However, in areas where there is no tertiary government hospital or the hospital is not capable to provide the required services, PhilHealth has the prerogative to contract private healthcare providers to render specialized care for catastrophic conditions strictly following the existing rules for contracting (PhilHealth Board Resolution No. 1904 s. 2014).

#### K. LIST OF ANNEXES (Annexes shall be uploaded in the PhilHealth website)

Annex "A": Pre-authorization Checklist and Request form

Annex "B": Member Empowerment (ME) Form

Annex "C": Checklist of Mandatory and Other Services

Annex "D": Z Satisfaction Questionnaire Annex "E": Tranche Requirement Checklists

Annex 'F": PD First Passport (Refer to PhilHealth Circular No. 2016-021) Annex "G": Letter of intent for transfer of PD Care to referral PD Center

(Refer to PhilHealth Circular No. 2016-021)

Annex "H": Transmittal Form

Annex "I": Methodology for the Policy Review

Annex "]": Summary of mandatory and other services

Annex "K": Summary of Z Benefit codes

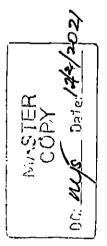
Annex "L": Field monitoring of the Z Benefits Annex 'M": Checklist of patient transfer (PD First)

(Refer to PhilHealth Circular No. 2016-021)

Annex "N": Summary of age requirements for the Z Benefits Annex "O": Breast Cancer Medical Records Summary Form Annex "P": List of additional services for complicated cases Annex "O": Summary of the validity of approved pre-authorization

Annex 'R": Summary of tranche payments

Annex "S": Summary of the definition of lost-to-follow-up





#### VI. PENALTY CLAUSE

Any violations of this circular, terms and conditions of the contract, and all existing related PhilHealth Circulars and directives shall be dealt with accordingly.

#### VII. SEPARABILITY CLAUSE

In the event that a part or provision of this Circular is declared unconstitutional or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

#### VIII. TRANSITORY CLAUSE

- A. Upon publication of this Circular, PhilHealth shall disseminate this information to contracted HCPs, and ensure the availability of revised forms in the website and the deployment of necessary revisions in the claims system;
- B. Claims filed with approved pre-authorizations prior to the date of the effectivity of this PhilHealth Circular shall follow the provisions of PhilHealth Circular No. 2015-035 entitled "The Guiding Principles of the Z Benefits;"
- C. Claims filed for the Z Benefits for Premature and Small Newborns with admission dates prior to the effectivity of this PhilHealth Circular shall follow the provisions of PhilHealth Circular No. 2015-035;
- D. All others not enumerated shall abide by this PhilHealth Circular upon its effectivity.

#### IX. REPEALING CLAUSE

This policy repeals PhilHealth Circular No. 2015-035 titled "The Guiding Principles of the Z Benefits" and PhilHealth Circular No. 2017-0014, Item V.B.2.d titled "Submission of Statement of Account (SOA) or its Equivalent for All Case Rates Claims Reimbursement (Revision 1)."

#### X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on January 1, 2022 after completion of publication in a newspaper of general circulation. A copy shall thereafter be deposited to the National Administrative Register at the University of the Philippines Law Center.

Please be guided accordingly.

President and Chief Executive Officer

Date Signed:

The Guiding Principles of the Z Benefits (Revision 1)





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Case No. \_

				Annex "	'A-ZMORPH"
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Conforme by F	Patient/Parent/Guar	dian:			Attending Rehabilitation cine Specialist
Printed	name and signature	<u> </u>	PhilHealth Accreditation No.	Printed	d name and signature



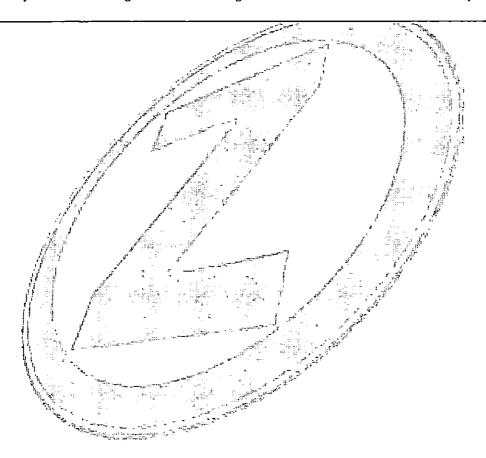


Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444 www.philhealth.gov.ph

#### 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 ZMORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

		DATE OF REQUEST (mm/dd	/ <i>yyyy</i> ):				
	Ī	This is to request approval for p	rovision	of service	es under the Z benefit package	for	
	ŀ						Ì
				in	(Name of HCI)		
		(Patient's last, first, suffix, middle under the terms and conditions a	e name)	l for am			
	Ł	under the terms and conditions a	as agreec	i ioi avai	mient of the Z Denent I ackage.		
		The patient is aware of the PhilHealth appropriate box):    Without co-payment   With co-payment, for the purpose	ترسخت	1 co-payme	ent and agreed to avail of the benefit po	ackage (plea	ase tick
	-		المحاسبون المجهر			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
		Certified correct by:	_r -		Certified correct by:	make make no control of the control	
		(Printed name and sign Attending Rehabilitation Medi		cialist	(Printed name and sign Executive Director/Chief Medical Director/ Medical	of Hospit	
	_ [	Phill-leath Accreditation No.			PhilHealth Accreditation No.		
	3/202				(Printed name and sig	onature)	
	श	Patient/Parent/Guardian					
μ>̈́	Date:		Fo	r PhilHe	alth Use Only)		•
ν		☐ APPROVED		gradus.			
\ن≥	_	DISAPPROVED (State reason/s)					
≥ '	2						
	২	(Printed name and signature)	)	<del>_</del> :2**			
	Ö	Head or authorized representative		ts Admi	nistration Section (BAS)		
		INITIAL APPLICAT	CIONI		COMPLIANCE TO REQ	TITDEME	NTTC
		Activity	Initial	Date	☐ APPROVED	CIREMIE	1413
		Received by LHIO/BAS:	AIIICIGI	Daic	☐ DISAPPROVED (State reaso	n/s)	
		Endorsed to BAS (if received by LHIO):			,	,	
		☐ Approved ☐ Disapproved			Activity	Initial	Date
		Released to HCI:			Received by BAS:		
		This pre-authorization is valid fo			☐ Approved ☐ Disapproved		
		eighty (180) calendar days from do of request.	iate of ap	proval	Released to HCI:		
		-				·	





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Case No.

Annex "A - ALL" HEALTH CARE PROVIDER (HCP) ADDRESS OF HCP 1. Last Name, First Name, Middle Name, Suffix A. PATIENT SEX □ -Male ☐ Female 2. PhilHealth ID Number B. MEMBER Same as patient (Answer the following only if the patient is a dependent) 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number 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 (✓) YES **QUALIFICATIONS** 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 If female, put "N/A" \* L3 morphology is excluded



Revised as of November 2021

Place a check mark (✓)

DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
CBC WBC count $<50,000/\mu$ L or $<50,000$ cells/ $\mu$ L or $<50$ x $10^3/\mu$ L or $<50$ x $10^9/$ L		
CSF cell count white blood cell (WBC) not more than 5 x 106/L		

Certified correct by Attending Physician:

(e.,	* * * , , , , ,		',		
	,	Printed n	ame and	signature	
in e	PhilHealth Accreditation No.				
esc.	, ,		1	•	
<b></b>	* *		, ,,	2	

Once approved, the contracted HCP shall print the approved pre-authorization form and have this signed by the parent or guardian and healthcare 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	provisio	n of serv	ices under the Z benefit packag	e for	
		(Davis and a Lat Court of Court	111	1	n (Name of <i>HCF</i>	<u>)</u>	
		(Patient's <i>last, first, suffix, mi</i> under the terms and condition	<i>aaie name</i> ) s as agre	ed for av	ailment of the Z-Benefit Packag		
						) — v — — — — — — — — — — — — — — — — — —	
			alth policy	on co-payn	nent and agreed to avail of the benefit	package (p	lease tick
		appropriate box):		Water San Comment	, i i i i i i i i i i i i i i i i i i i		
		☐ Without co-payment☐ With co-payment, for the purpo	se of	A STATE OF THE PARTY OF THE PAR			
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	1	Certified correct by:			Certified correct by:		
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	V	(Printed name and si	onature)	<mark>ge<sup>ee</sup> </mark>	(Printed name and	sionature)	
	9	Attending Physic		•	Executive Director/Chie		
	1,-		a de la companya de l	· tare*	Medical Director/ Medic		
•	1	PhilHealth Accreditation No.			PhilHealth Accreditation No.		-
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	Dati		# P		Conforme by:		
3.C	-			97°41	Specific to the second		
	5			90 F	(Printed name and		
	3				Parent/Guard	<u> </u>	
	S	,	Fo	r Phill-le:	alth Use Only)		
		~☐ APPROVED	en er		पा हे:		
		☐ DISAPPROVED (State re	ason/s)	. Mar.			
		,					
		(Printed name and signatu	ma)	<u> </u>			
		Head or authorized representative,		Administ	tration Section (BAS)		
		INITIAL APPLICAT			COMPLIANCE TO REQ	UIREME	NTS
	ļ	Activity	Initial	Date	☐ APPROVED ☐ DISAPPROVED (State reason	n/s)	ĺ
	ŀ	Received by LHIO/BAS:			DISALTIOVED (State least	(3 ענוי	
		Endorsed to BAS	ľ				
		(if received by LHIO):			(Printed name and signa Head or authorized BAS rep		İ
		☐ Approved ☐ Disapproved			Activity	Initial	Date
		Released to HCP:			Received by BAS:		
		This pre-authorization is valid fo			☐ Approved ☐ Disapproved	,	
	calendar days from date of approval of request.			Released to HCP:			





UNIVERSAL HEALTH CARE

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HEALTHCARE PROVIDER (HCP)  ADDRESS OF HCP  A. PATIENT 1. Last Name, First Name, Suffix, Middle Name   SEX   Male   Fee   Fee	
A PATIENT 1. Last Name, First Name, Suffix, Middle Name  2. PhilHealth ID Number  3. B. MEMBER	
2. PhilHealth ID Number  B. MEMBER  Comparison of the patient is a dependent)  1. Last Name, First Name, Suffix, Middle Name  2. PhilHealth ID Number  The patient is a dependent)  1. Last Name, First Name, Suffix, Middle Name  2. PhilHealth ID Number  The proceed to pre-authorization application in No. If no, specify reason/s and encode  PRE-AUTHORIZATION CHECKLIST  Early Breast Cancer  Place a check mark  Yes  1. No previous chemotherapy for breast cancer  Place a check mark  The provious radiotherapy for breast cancer  Place a (*) in CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCCNCCN v1.2022)  CStage 0: Tis (ductal carcinoma-in-siti) NO MO	
B. MEMBER	male
1. Last Name, First Name, Suffix, Middle Name  2. PhilHealth ID Number  Fulfilled selections criteria Yes If yes, proceed to pre-authorization application  No If no, specify reason/s and encode  PRE-AUTHORIZATION CHECKLIST  Barly Breast Cancer  Place a check mark  QUALIFICATIONS  1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AICCNCCN v1.2022)  CStage 0: Tis (ductal carcinoma-in-situ) NO MO	
Fulfilled selections criteria Yes If yes, proceed to pre-authorization application No If no, specify reason/s and encode  PRE-AUTHORIZATION CHECKLIST  Early Breast Cancer  Place a check mark  QUALIFICATIONS  1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AICCNCN v1.2022)  CStage 0: Tis (ductal carcinoma-in-sitin) NO MO	
Fulfilled selections criteria Yes If yes, proceed to pre-authorization application No If no, specify reason/s and encode  PRE-AUTHORIZATION CHECKLIST  Early Breast Cancer  Place a check mark  Yes  1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCCNCCN v1.2022)  CStage 0: Tis (ductal carcinoma-in-siti) NO MO	
PRE-AUTHORIZATION CHECKLIST  Early Breast Cancer  Place a check mark  QUALIFICATIONS  1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (\script ) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCCNCCN v1.2022)  CStage 0: Tis (ductal carcinoma-in-situ) NO MO	
PRE-AUTHORIZATION CHECKLIST  Early Breast Cancer  Place a check mark  QUALIFICATIONS  1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (\scales) is bilateral) (Early breast cancer definitions, Source: AJCC-NCCN v1.2022)  CStage 0: Tis (ductal carcinoma-in-siti) N0 M0	
PRE-AUTHORIZATION CHECKLIST  Early Breast Cancer  Place a check mark  Yes  1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCCNCCN v1.2022)  cStage 0: Tis (ductal carcinoma-in-siti) NO MO	
QUALIFICATIONS  1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCC NCCN v1.2022)  cStage 0: Tis (ductal carcinoma-in-situ) N0 M0	
1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCC-NCCN v1.2022)  cStage 0: Tis (ductal carcinoma-in-situ) N0 M0	
1. No previous chemotherapy for breast cancer  2. No previous radiotherapy for breast cancer  Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCG-NCCN v1.2022)  cStage 0: Tis (ductal carcinoma-in-situ) N0 M0	
Place a (*) i  CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCC-NCCN v1.2022)  cStage 0: Tis (ductal carcinoma-in-situ) N0 M0	-
CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions, Source: AJCC-NCCN v1.2022)  cStage 0: Tis (ductal carcinoma-in-situ) N0 M0	
bilateral) (Early breast cancer definitions, Source: AJCCNCCN v1.2022)  cStage 0: Tis (ductal carcinoma-in-situ) N0 M0	if YE
cStage 0: Tis (ductal carcinoma-in-situ) NO MO	Botl
oStage IA T1 (rumor 20mm) NO MO	
<u> </u>	
cStage IB: T0 N1mi M0; T1 (tumor <20mm) N1mi M0	
cStage IIA: T0 N1 M0; T1 N1 M0; T2 (tumor>20mm but <50mm) N0 M0	
cStage IIB: T2 N1 M0; T3 (tumor>50mm) N0 M0	
cStage IIIA: T0 N2 M0; T1 N2 M0; T2 N2 M0; T3 N1 M0; T3 N2 M0	
Certified correct by Attending Certified correct by Attending Conforme by Pa Medical Oncologist: Surgeon:	atien
Printed name and signature Printed name and signature Printed name PhilHealth Accreditation No. PhilHealth Accreditation No. signature	
PhilHealth Accreditation No. PhilHealth Accreditation No. signature  Revised as of November 2021	e

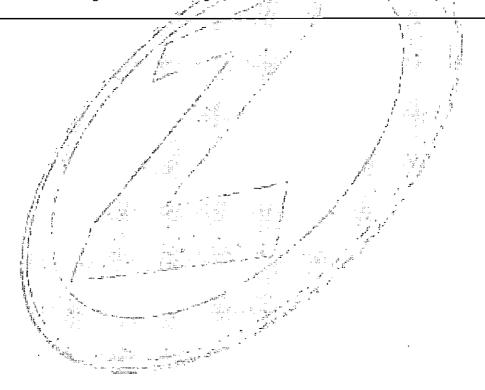


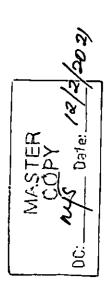


#### Note:

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

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









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## PRE-AUTHORIZATION REQUEST Early Breast Cancer

	DATE OF REQUEST (mm/dd/yyyy):					
	This is to request approval for	provisio	n of serv	rices under the Z benefit packag	e for	
	(Patient's last, first, suffix, mid under the terms and condition		ed for av	(Name of <i>HCP</i> ) railment of the Z Benefit Packag	ge.	
	The patient is aware of the PhilHea appropriate box):    Without co-payment   With co-payment, for the purpo	ئىرىيە ئىمىرە	on co-pays	ment and agreed to avail of the benefit	package (p	lease tick
	Certified correct by:		and the second	Certified correct by:	The state of the s	
	(Printed name and sig Attending Surgeo			(Printed name and s Attending Medical C		:
202	PhilHealth Accreditation No.			PhilHealth Accreditation No.	, n	
200	Conforme by:		· · · · · · · · · · · · · · · · · · ·	Certified correct by:		
TER PY Date:	(Printed name and sig	nature)		(Printed name and s Executive Director/Chie Medical Director/ Medica	f of Hosp	
\$05/		The defined depth to the san a	- معسمه بنینجیدی ۱۹۰۱ اکمنی	PhilHealth Accreditation No.		<u> </u>
,	☐ APPROVED☐ DISAPPROVED (State re	y		alth Use Only)		
	(Printed name and signature Head or authorized representative,		— Adminis	tration Section (BAS)		
	INITIAL APPLICAT		_	COMPLIANCE TO REQ	UIREME	NTS
	Activity Received by LHIO/BAS:	Initial	Date	│ □ APPROVED │ □ DISAPPROVED (State reaso	on/s)	
	Endorsed to BAS (if received by LHIO):			(Printed name and sign Head or authorized BAS rej		
	☐ Approved ☐ Disapproved			Activity	Initial	Date
	Released to HCP:	:		Received by BAS:		
	This pre-authorization is valid fo calendar days from date of appro			☐ Approved ☐ Disapproved Released to HCP:		
	calcadar days nom date or appro			Neicased to FICP:	1	



Revised as of November 2021

Page 3 of 3 of Annex A - Breast CA

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Case No	
	Annex "A – CABG"
HEALTHCARE PROVIDER (HCP)	
ADDRESS OF HCP	
A. PATIENT 1. Last Name, First Name, Suffix, Middle Name	SEX
2. PhilHealth ID Number -	TT TT -
B. MEMBER    Same as patient (Answer the following only if the patient is a deposit of	endent)
2. PhilHealth ID Number	"", "E <sub>n</sub>
Fulfilled selections criteria	
PRE-AUTHORIZATION CHECKLIS Standard Risk Elective Coronary Artery Bypass Graft (	
QUALIFICATIONS	YES
At least 19 years of age	
ATTESTED BY ATTENDING CARDIOLOGIST of CARDIO	VASCULAR SURGEON  Place a check mark (  )
QUALIFICATIONS	YES
1. Stable coronary artery disease requiring ELECTIVE ISOLATED indication based on coronary anatomy, symptom severity, left ven function, and/or viability tests; non-invasive testing completed an with patient	ntricular
Check current medical status:     a. NOT in severe decompensated heart failure by New York Classification (NYFCIV)	
b. NOT with severe angina by Canadian Cardiovascular Soc Class IV)	iety (CCS
c. NO other cardiac/vascular procedures/interventions plan	
done with coronary artery bypass graft surgery during this d. NO history of dialysis and NO current requirement of dia	alysis



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Place a check mark (✓)

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

Place a check mark ( )

DIAGNOSTICS*	YEŞ	DATE DONE (mm/dd/yy)
1. Coronary Angiography: coronary anatomy amenable for CABG and consistent with Class I and IIa indications for CABG surgery and discussed with patient	7	
Current status of myocardial viability consistent with benefit from CABG and discussed with patient		**

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

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

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

MASTER COPY C: Mys Date: 12/2/20

Note:

Once approved, the contracted *HCP* shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the LHIO or PRO when filing the first tranche.

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







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

DATE OF REQUEST (mm/dd/yyyy):							
This is to request approval for provision of services under the Z benefit package for							
•							
(Patient's last first suffix min	ddle name\	,		)	<u>-</u>		
		ed for av					
appropriate box):  Without co-payment		on co-payn	ment and agreed to avail of the benefit	package (p	lease tick		
with to-payment, for the purpo.	se oj:	2 (1200 - (1200 - (1200)	and Tigg,	5 No.			
Certified correct by:	المعمودية المواجعة المواجعة المواجعة		Certified correct by:				
Phili-lealth Accreditation No.		A 192 A 193	Phili-Leath Accreditation No.	# 1 m			
Conforme by:	Appende and		Certified correct by:				
(Printed name and sig	gnature)		Executive Director/Chi	ef of Hos	oital/		
(For PhilHealth Use Only)  □ APPROVED □ DISAPPROVED (State reason/s)							
			A STATE OF THE STA				
(Printed name and sign	ature)	T_ler					
Head or authorized representative, I	Benefits	Adminis	tration Section (BAS)				
INITIAL APPLICAT	TION		COMPLIANCE TO REQ	UIREME	NTS		
Activity	Initial	Date	☐ APPROVED		1		
<del></del>			☐ DISAPPROVED (State reaso	on/s)	İ		
Endorsed to BAS (if received by LHIO):							
☐ Approved ☐ Disapproved			Activity	Initial	Date		
Released to HCP:			Received by BAS:				
This pre-authorization is valid for one hundred							
		undred	☐ Approved ☐ Disapproved				
	(Patient's last, first, suffix, minunder the terms and condition  The patient is aware of the PhilHea appropriate box):  Without co-payment  With co-payment, for the purpo  Certified correct by:  (Printed name and sign Attending Cardiol PhilHealth Accreditation No.  (Printed name and sign Patient  APPROVED  DISAPPROVED (State results)  (Printed name and sign Head or authorized representative, Initial Application No.  INITIAL APPLICATIONS (if received by LHIO/BAS: Endorsed to BAS (if received by LHIO):  Approved □ Disapproved	(Patient's last, first, suffix, middle name) under the terms and conditions as agre  The patient is aware of the PhilHealth policy appropriate box):  □ Without co-payment  □ With co-payment, for the purpose of:  (Printed name and signature)  Attending Cardiologist  PhilHealth Accreditation No.  (Printed name and signature)  Patient  (Printed name and signature)  Patient  (Printed name and signature)  Head or authorized representative, Benefits  INITIAL APPLICATION  Activity Initial  Received by LHIO/BAS:  Endorsed to BAS (if received by LHIO):  □ Approved □ Disapproved	This is to request approval for provision of serve (Patient's last, first, suffix, middle name) under the terms and conditions as agreed for average appropriate box):    Without co-payment   With co-payment, for the purpose of:    Certified correct by:    (Printed name and signature)   Attending Cardiologist	This is to request approval for provision of services under the Z benefit package in (Patient's last, first, suffix, middle name) (Name of HCP under the terms and conditions as agreed for availment of the Z Benefit Package.  The patient is aware of the Phill-lealth policy on co-payment and agreed to avail of the benefit appropriate box):  Without co-payment for the purpose of:  Certified correct by:  (Printed name and signature)  Attending Cardiologist Attending Cardiovasc.  Phill-lealth Accreditation No.  Conforme by:  (Printed name and signature)  Approved Disapproved Disapproved	This is to request approval for provision of services under the Z benefit package for  in  (Patient's last, first, suffix, middle name)  under the terms and conditions as agreed for availment of the Z Benefit Package.  The patient is aware of the Philf-lealth policy on co-payment and agreed to avail of the benefit package (pappropriate box):  Without co-payment, for the purpose of:  Certified correct by:  (Printed name and signature)  Attending Cardiologist  Attending Cardiovascular Surge  Philf-bath Accorditation No.  Conforme by:  (Printed name and signature)  Patient  (Printed name and signature)  Patient  (For Philf-bath) Accorditation No.  (For Philf-bath) Accorditation No.  (Printed name and signature)  Patient  (For Philf-bath) Accorditation No.  (Printed name and signature)  Philf-bath Accorditation No.  (For Philf-bath) Accorditation No.  (Printed name and signature)  Philf-bath Accorditation No.  (Printed name and signature)  (Printed name and signature)  Philf-bath Accorditation No.  (Printed name and signature)  Philf-bath Accorditation No.  (Printed name and signature)  DISAPPROVED  DISAPPROVED  COMPLIANCE TO REQUIREME Activity  Initial  Approved Disapproved  Activity  Initial  Activity  Initial		





# Republic of the Philippines



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Case No				
			Annex ".	A – Cervical CA"
HEALTH CAI	RE PROVIDER (HCP)		<u> </u>	
	, ,			
ADDRESS OF	НСР		-	
A. PATIENT	1. Last Name, First Name	Suffix, Middle	Name 3	SEX
A THE STATE OF THE		, , 		□ Male □ Female
	2. PhilHealth ID Number	r	The state of the s	
B. MEMBER	☐ Same as patient (Answer th	ne following only if the p	oatient is a dependent)	***. * ********************************
	1. Last Name, First Name	, Şuffix, Middle 1	Name	
	in set set set set set set set set set set			
	2. PhilHealth ID Number	-	2	
	The state of the s			* 3
Fulfilled sele	ctions criteria 🔎 Yes 🗓	f yes, proceed to	pre-authorization a	pplication
	//	f no, specify rea	son/s and encode	
		· · · · · · · · · · · · · · · · · · ·		
	A CONTRACT OF THE STATE OF THE	,		18
	PRE-AUTHO	RIZATION CH	IECKLIST	<i>y</i> <sup>2</sup> ,
į	, Če	rvical Cancer		<b>.</b>
il.			¿ Plac	ce a check mark (✓)
QUALIFICA'	ΓIONS /	***	- John State Committee Com	YES
1. Biopsy	result 🦯	, t		
2. No pre	vious radiotherapy for cervi	cal cancer	4	
3. No pre	vious chemotherapy for cer	vical cancer	TO SECURE	
	ent plan	· //*		
5. No uno	controlled co-morbid condit	ions		
	**************************************	ace a check marl	x ( <b>v</b> )	
FIGO	Clinical Staging	YES	<u> </u>	(mm/dd/yyyy)
Stages: (Choo		3,220	3111233112	(11111/ 24/ 33/33)
	A1		-	
Stage I				
Stage I		-		
Stage I				
Stage I		<u> </u>		
Stage I				
	<u> </u>	Certified correct	by Attending Gyne	ecologic-Oncologist:
				-
			Printed name and	signature
		PhilHealth		]-
		Accreditation No	·	



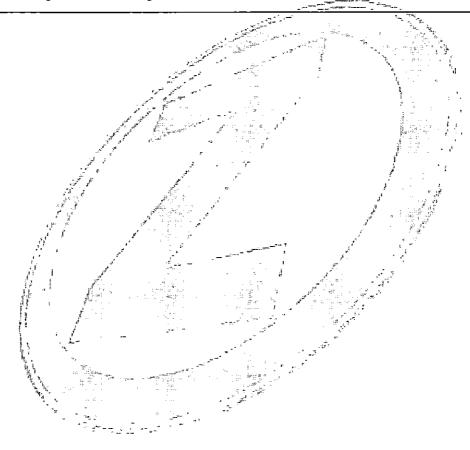


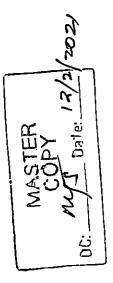
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Note: Once approved, the contracted *HCP* shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (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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Page 2 of 3 of Annex A - Cervical CA
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# Republic of the Philippines

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PRE-AUTHORIZATION REQUEST

**Cervical Cancer** 



DATE OF REQUEST (mm/dd/yyyy):						
This is to request approval for	This is to request approval for provision of services under the Z benefit package for					
in					}	
(Patient's last, first, suffix, middle name) (Name of HCP) 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):						
The patient is aware of the PhilHead payment and agreed to avail of the letick appropriate box):  Without co-payment  With co-payment, for the purpo	alth policy penefit pac	on co-	Treatment modality: (tick ap	herapy, co dose) or p 2-11A1 herapy, li	obalt orimary near	
Certified correct by:	y Justin		Certified correct by:	î î		
** ***********************************		<i>,</i>				
(Printed name and si			(Printed name and signature)			
Attending Gynecologic-	Oncolo	gist	Executive Director/Chief of Hospital/			
			Medical Director/ Medical	l Center	Chief	
Accreditation No.			Accreditation No.		-	
			Conforme by:  (Printed name and s Patient	ignature)		
□ APPROVED □ DISAPPROVED (State re	The state of the s	r Phill le	alth Use Only)			
And the second s		San San San San San San San San San San				
	(Printed name and signature)  Head or authorized representative, Benefits Administration Section (BAS)					
INITIAL APPLICAT	ION		COMPLIANCE TO REQU	JIREMEN	ITS	
Activity Received by LHIO/BAS:	Initial	Date	☐ APPROVED☐ DISAPPROVED (State reason/s	-		
Endorsed to BAS (if received by LHIO):			(Printed name and signa Head or authorized BAS rep	ture)		
☐ Approved ☐ Disapproved		_	Activity	Initial	Date	
Released to HCP:			Received by BAS:			



This pre-authorization is valid for sixty (60) calendar days from date of approval of request.

Released to HCP:

☐ Approved ☐ Disapproved



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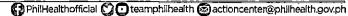


Case No.

	<del></del>		Annex "	A1-EMORPH"				
HEALTH CAI	RE INSTITUTION (HCI)							
ADDRESS OF	FHCI							
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX  ☐ Male ☐ Female							
	2. PhilHealth ID Number							
B. MEMBER	EMBER (Answer only if the patient is a dependent; otherwise, write, "same as above")  1. Last Name, First Name, Middle Name, Suffix							
	2. PhilHealth ID Number							
		o, specify reason/	s and encode					
PRE-	AUTHORIZATION CHEC Upper and Lov	ver Limb Prosth	esis	1				
OUALIFI	CATIONS / /	Place	a (v) II yes o	or NA if not applicable				
<del>-</del>	18 years old	, in the second						
	three months post-amputation	on, if acquired						
c. Wheeld	hair independent, community	-ainbulator with	or without					
crutche	s, cane or walker	•	هر					
d. On phy	sical examination: no fresh o	r non-healing wo	ound, 🛫					
neuron	na or painful residual limb, no	motor strength	of <4/5 and	: <del>Le</del>				
	on of motion of upper and/o	r lower limbs, no	) * , ,					
	lination or poor balance							
Place a check n	$\frac{1}{2}$ on the type of prosther							
T T 1' 1	Z Benefits*	Right	Left	Both				
I. Lower limb	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, , , , , , , , , , , , , , , , , , ,	- " <i>"</i>					
	knee/ knee disarticulation articulation							
	ess Rotationplasty							
II. Upper limb		_1						
A. Below								
B. Above				"				
	ing more than one amputations, th	e patient cannot cla	im for two pro	stheses with the same				
Conforme by P	atient/Parent/Guardian:			attending Rehabilitation eine Specialist				
Printed		uilHealth ccreditation No.	Printec	name and signature				



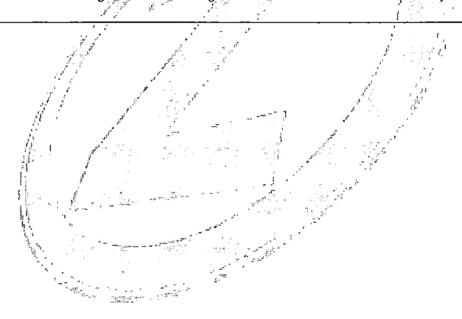
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#### Note:

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 p	provision	of service	es under the Z benefit package	for	
		غ خ			
(D) 1 1 1 0 0 0 0 11	,, \	<b>II</b> ت <u>همه در</u> مستور مستورد	AL-S-ETICA		
(Patient's last, first, suffix, midal under the terms and conditions		for avai	(Name of HCI)		
under the terms and conditions	as agreed	# 101.ava	inficit of the 2 Deficit I ackage.	* 68	
The patient is aware of the Phill-Lealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):    Without co-payment   With co-payment, for the purpose of:					
Contilled comment like	- AA		Certified correct by:	<u> </u>	<del></del> -
Certified correct by:	A CONTRACTOR OF THE PARTY OF TH		Centined correct by:		
(Printed name and sign	nature)		(Printed name and sig	gnature)	
Attending Rehabilitation Med	icine Spe	cialist "			
it and the second		<u> </u>	Medical Director/Medical	Center C	hief
PhilHealth Accreditation No.					-
(Printed name and signature) Patient/Parent/Guardian					
The state of the s	/Fo	r Dhillo	alth Use Only)		
The state of the s	(I:0	ı rımı æ	aith Ose Only)		
☐ APPROVED					
☐ DISAPPROVED (State reas	son/s) _		<del></del>	_	
(Printed name and signature	<u> </u>	_			
Head or authorized representativ	re, Benefi	its Admi	nistration Section (BAS)		
INITIAL APPLICA	TION		COMPLIANCE TO REQ	HIREME	NTS
Activity	Initial	Date	☐ APPROVED	011001112	
Received by LHIO/BAS:			☐ DISAPPROVED (State reaso	n/s)	
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			Activity	Initial	Date
Released to HCI:			Received by BAS:		
This pre-authorization is valid for			☐ Approved ☐ Disapproved		
eighty (180) calendar days from of request.	date of ap	proval	Released to HCI:		-





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Case No.

	Annex "A2 – EM	IORPH"				
HE	ALTH CARE INSTITUTION (HCI)					
AD	DRESS OF HCI	· · · · · · · · · · · · · · · · · · ·				
A. J	PATIENT 1. Last Name, First Name, Middle Name; Suffix SEX	5, 18m.				
	2. PhilHealth ID Number	- 1				
В.1	MEMBER (Answer only if the patient is a dependent; otherwise, write, "same as ab  1. Last Name, First-Name, Middle Name, Suffix  2. PhilHealth ID Number	ove")				
Fi	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					
1.	GENERAL QUALIFICATIONS	Yes				
2.	Age ≥ 18 years old  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	f not applicable				
	QUALIFICATIONS SPECIFIC TO ANKLE FOOT ORTHOSIS	Yes				
1.	Weakness or absence of dorsiflexors and/or plantarflexors, +/- grade 1-					
2.	2 spasticity with full range of motion achieved passively  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					



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	Plac	e a ( V ) if yes o	ir INA II not a	аррисавие
QUALIFICATIONS SPECIFIC TO KNEE				Yes
Quadriceps MMT of <3 +/- sensory loss ,+/ with hip/knee flexion contracture <20 degree		genu recurvat	um)	
	, Plac	e a (√) if yes o	r NA if not	applicable
QUALIFICATIONS SPECIFIC TO HIP K ORTHOSIS				Yes
Hip, knee, ankle & foot muscles MMT <3 +/ with hip /knee flexion contracture <20 degree		ss, +/- instabil	lity,	₹ *
Place a check mark ( ) on the type of orthoses	to be given t	to the patient:		
Z Benefits		Right	Left	Both
Ankle Foot Orthosis			7	
Knee Ankle Foot Orthosis		***		
Hip Knee Ankle Foot Orthosis	he <sup>ret</sup>			
Conforme by Patient/Parent/Guardian:			Attending Reicine Speciali	
	Health reditation No.	Printe	ed name and	signature
Note: Once approved, the contracted hospital shall pring signed by the patient, parent or guardian and heat submitted to the Local Health Insurance Office (when filing the first tranche.	lth care provid	lers, as applicabl	le. This form	shall be

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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Page 2 of 3 of Annex A2 - EMORPH
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## PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH Lower Limb Orthosis

	DATE OF REQUEST (mm/dd/yyyy):						
	This is to request approval for provision of services under the Z benefit package for						
					: - ; - 3-4 ; - 3-4 		
	(Patient's last, first, suffix, mid	ddle name)	معمد المعمد ا	(Name of HCI	) San Yuk		
	under the terms and conditions as agreed for availment of the Z Benefit Package.						
	The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):  Without co-payment  With co-payment, for the purpose of:						
	Certified correct by:			Conflict comparity	(高水) 夏龙	<del></del>	
	Certified correct by:		a de la companya de l	Certified correct by:			
	(Printed name and si	gnature)	المعلومين المعاون المعاون	(Printed name and			
	Attending Rehabilitation Medicine Specialist Executive Director/Chief of Hospital/						
\	Medical Director/ Medical Center Chief Phill Health Phill Health						
	Accreditation No.			Accreditation No		<u>                                     </u>	
	Conformé by:  (Printed name and signature) Patient/Parent/Guardian						
1		ίFo	r PhilHe	alth Use Only)			
	□ APPROVED	(					
1	☐ DISAPPROVED (State re	ason/s)					
			-			<del></del> -	
,	(Printed name and signatur		.C	-iii (n.xe)			
_	Head or authorized representat		ents Adn				
-	INITIAL APPLICATION COMPLIANCE TO REQUIREMENTS						
-	Activity Received by LHIO/BAS:	Initial	Date	<ul><li>□ APPROVED</li><li>□ DISAPPROVED (State reason</li></ul>	m/s)		
-	Endorsed to BAS (if received by			= 210111110 VID (DIACE TEASE	sj	-	
	LHIO):						
	☐ Approved ☐ Disapproved			Activity	Initial	Date	
	Released to HCI:			Received by BAS:			
	This pre-authorization is valid fo			□ Approved □ Disapproved			
	eighty (180) calendar days from of request.	Released to HCI:					





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Case No	<del></del>	
	Annex "A3 -	-EMORPH"
HEALTH CA	RE INSTITUTION (HCI)	-
ADDRESS OF	FHCI	
A PATIENT		fale. □ Female
	2. PhilHealth ID Number	
B. MEMBER	(Answer only if the patient is a dependent; otherwise, write, "same as ab  1. Last Name, First Name, Middle Name, Suffix	ove")'
	2. PhilHealth ID Number	n k
PRE	Place a (V) if yes or NA i	RPH f not applicable
	Qualifications 'years old	Yes
2. Upon dia	gnosis and/or post-operative clearance	
	ry deficit over body segment of application d lower limb manual muscle strength of ≥ 3	_
	Place a (✔) if yes or NA i	
	umbar (T12-L2) spinal fractures involving posterior elements	Yes
	or metastatic lesions to the thoracolumbosacral spine	
	Place a (✓) if yes or NA i	f not applicable
	tions for Lumbosacral Spinal Orthosis	Yes
1. Lumbosa	cral fractures (L1-L3)	



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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	A motionts
Tick the box corresponding to the type of spinar orthogs to be given to the	e pacient.
☐ Thoracolumbosacral custom molded spinal orthosis	
☐ Lumbosacral custom molded spinal orthosis	
☐ Cervicothoracic custom molded spinal orthosis	
and the state of t	
Conforme by Patient/Parent/Guardian: Attested by	Attending Rehabilitation
Męd Med	licine Specialist
	· · · · · · · · · · · · · · · · · · ·
Printed name and signature  PhilHealth  PhilHealth	ed name and signature
Accreditation No.	
All the second s	
<u></u>	
Note: Once approved, the contracted hospital shall print the approved pre-authoriz	ation form and have this
signed by the patient, parent or guardian and health care providers, as applical	
submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Re	
when filing the first tranche.	
There is no need to attach laboratory results. However, these should be incl	
and may be checked during the field monitoring of the Z Benefits. Please do	o not leave any item diank.





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### PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH Spinal Orthosis

	DATE OF REQUEST (mm/dd/yyyy):									
	This is to request approval for provision of services under the Z benefit package for									
	inin									
	(Patient's last, first, suffix, mu	iaaie name) Is as agte	ed for av	(Name of HCI	/ <sub>ic</sub> re. :					
	under the terms and conditions as agreed for availment of the Z Benefit Package.									
	The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick									
	appropriate box):									
	□ Without co-payment	ا ميراند. ما موراند و مراهمون	• **							
	With co-payment, for the purpo	osë of:								
	Certified correct by:			Certified correct by:						
	Cerumen correct by:			Certified correct by:	( ) Apr					
	(Printed name and si			(Printed name and						
	Attending Rehabilitation Me	pecialist	Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief							
	PhilHealth	- j <sup>or</sup> ,		Medical Director/ Medic	al Center	Chief				
બ	Accreditation No.		- -	Accreditation No.		-				
8			Conforme by:							
1				Comornie by.						
$\downarrow$	To any order		2 2 2 m	(Printed name and	signature)	l				
		. *		Patient/Parent/Guardian						
9			TOT THE	11 77 041						
3		". (Fo	r PhilHea	ılth Üse Only)						
	☐ APPROVED	# # *		•						
	☐ DISAPPROVED (State re	eason/s)								
	<u> </u>									
5	(Printed name and signatu	re)								
	Head or authorized representat		efits Adm	inistration Section (BAS)						
_	-				_					
	INITIAL APPLICA'			COMPLIANCE TO REQ	UIREME	NTS				
	Activity	Initial	Date	☐ APPROVED	- (a)					
-	Received by LHIO/BAS: Endorsed to BAS (if received by			☐ DISAPPROVED (State reaso	лг, 2)					
	LHIO):	] ,								
İ	☐ Approved ☐ Disapproved			Activity	Initial	Date				
	Released to HCI:			Received by BAS:						
Ì	This pre-authorization is valid for			☐ Approved ☐ Disapproved						
	eighty (180) calendar days from of	date of ap	proval	Released to HCI:						





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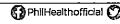
	Case No	x "A – KT"
	Time.	A ZK AXI
	HEALTH CARE PROVIDER (HCP)	
	ADDRESS OF HCP	
	A. PATIENT 1. Last Name, First Name, Middle Name, Suffix SEX   Male	□ Female
	2. PhilHealth ID Number	
	B. MEMBER	
·	2. PhilHealth ID Number	<u> </u>
		_
STER	Fulfilled selections criteria  Yes If yes, proceed to pre-authorization applicate No If no, specify reason/s and encode	tion
Ž C	PRE-AUTHORIZATION CHECKLIST	
	End Stage Renal Disease requiring Kidney Transplantation (Low Ris	k)
	ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURG	ZEON
	(Place ✓ if YES or NA if no	
	QUALIFICATIONS	YES
	1. On chronic dialysis because of end stage renal disease except for pre-emptive	
	kidney transplantation	
	2. Anti-HCV negative	
	3. Absence of current severe illness (congestive heart failure class 3-4), liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension), chronic lung disease requiring	
	oxygen, etc.  4. Absence of the following: hemiparalysis, mental incapacity such that informed	
	consent cannot be made, and substance abuse for at least 6 months prior to	
	start of transplant work-up.  5. No previous history of cancer (except basal cell skin cancer).	
	6. If patient is HIV-positive, the HIV-1 RNA viral load should be below	
	detectable levels while on anti-retroviral therapy (<50 copies/mL) and CD4+ count should be >200 cells/mm3	



(Place ✓ if YES or NA if not applicable)

QUALIFICATIONS	YES					
7. If the patient is HbsAg positive, all the following conditions must be met:						
(If NA, write "NA" under 7a, b, c, and d, then proceed to Item No. 8.)  a. absence of liver cirrhosis						
b. HBV- DNA <2,000 IU/ml						
c. cleared by a gastroenterologist, who is a member of the medical staff of	_					
the transplant facility						
Clearance by the gastroenterologist						
Printed name and signature of						
gastroenterologist						
PhilHealth Accreditation No.						
d. The patient is informed that if there shall be additional cost of other						
interventions, these shall be sourced from other financing sources.						
I was informed that if there shall be additional cost of other interventions,						
these shall be sourced from other financing sources; and I understand that I						
will require antiviral prophylaxis for as long as it is indicated.						
Conformed by:						
Printed name and signature						
☐ patient ☐ parent ☐ guardian						
8. If the recipient is CMV IgG negative, any of the following should qualify:  (If NA, write "NA" junder 8a and b.)						
a. Donor should be CMV IgG negative; OR						
b. Recipient is CMV IgG negative and donor is CMV IgG positive:						
I understand that I will require CMV prophylaxis for as long as it is indicated and I am informed that I will be responsible for the additional cost						
of this medication and other interventions.						
And the second s						
Conformed by:						
Printed name and signature						
☐ patient ☐ parent ☐ guardian						
_ Fundam — Fundam — Summan						
Te Date of the Control of the Contro						





	DIAGNOSTICS							
	1. For pre-emptive kidney transplant and diabetic: 24-hour urine creatinine							
	clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or							
	nuclear GFR should be less than 20 mL/min /1.73m <sup>2</sup>							
	2. For pre-emptive kidney transplant and non-diabetic: 24-hour urine creatinine							
	clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or							
	nuclear GFR should be less than 15 mL/min /1.73m <sup>2</sup>							
	3. Low risk:	☐ Yes						
	a. Primary kidney transplant (no previous solid organ transplant)							
	b. Single organ transplant	□ Yes						
	c. Negative tissue crossmatch	□ Yes						
	d. Historical Panel Reactive Antibody (PRA) Class 1 & 2 negative	□ Yes						
		"No", answer e.1 and e.2						
	e. If Historical Panel Reactive Antibody (PRA) Class 1 and/or 2 is positive, must fulfill the following:							
	e.1 Historical PRA less than or equal to 20%	☐ Yes						
	e.2 No donor specific antibody (DSA) in the potential recipient	☐ Yes						
n-								
MASTER COPY	Certified Correct by Attending Nephrologi	st or						
301	Transplant Surgeon:							
30								
	Printed name and signature							
	PhilHealth Accreditation No.							

#### Note:

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

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

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

DATE OF REQUEST (mm/dd/yyyy)								
		- f						
	This is to request approval for provision of services under the Z benefit package for							
		i	n					
	(Patient's last, first, suffix, middle name)	(Name of HCF						
	under the terms and conditions as agree	d for av	ailment of the Z Benefit Packag	e.				
	The trational is surement the Dhill and the clima			'A (A	J +: . J.			
	The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):							
	appropriate box):      Without co-payment							
	☐ With co-payment, for the purpose of:	AND DESCRIPTION OF THE PARTY OF						
	A Company of the Comp	_		11	·			
	Conforme by Patient/Parent/Guardian:	1 m 1 m	Certified correct by: (for Serv	ice Patien	its)			
~		The state of the s		19				
6	(Printed name and signature)		(Printed name and	signature)				
742	Certified correct by:	مميمو	Please tick appropriate box	i at	,			
<u></u>	h <i>37 /</i> 300	i g	Chair, Department of Ad					
		<i>F</i>	☐ Chair, Dept. of Pediatric Nephrology					
्य	(Printed name and signature)		Chair, Department of Organ Transplantation  Executive Director/Chief of Hospital/					
Ţ Ž Ž	Attending Nephrologist	المستحدث مندورون	Medical Director/Medical Center Chief					
<u> </u>	Phili-Tealth	<u> </u>	PhilHealth					
30/A	Accreditation No.							
≥ 3								
` \	(For PhilHealth Use Only)							
	APPROVED	The state of the s	of the grant of the second of					
	DISAPPROVED (State reason/s)	1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			<del></del>			
	(Printed name and signature)	<u></u>						
	Head or authorized representative, Benefits A	Administ	cration Section (BAS)					
	INITIAL APPLICATION	COMPLIANCE TO REQ	UIREME:	NTS				
	Activity Initial	Date	APPROVED	- (a)				
	Received by LHIO/BAS:		☐ DISAPPROVED (State reaso	n/s)				
	Endorsed to BAS							
	(if received by LHIO):		(Printed name and signa					
	☐ Approved ☐ Disapproved		Head or authorized BAS rep	Initial	Data			
}	Released to HCP:		Activity Received by BAS:	iminar	Date			
	This pre-authorization is valid for one hund	dred	<u> </u>					
	eighty (180) calendar days from date of app		☐ Approved ☐ Disapproved					
ľ	of request.		Released to HCP:					



Revised as of November 2021

Page 4 of 4 of Annex A - KT
PhillHealthofficial teamphilhealth actioncenter@philhealth.gov.ph



### Republic of the Philippines

UNIVERSAL HEALTH CARE

PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City

Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444

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	Case No		
		Anne	x A – "Prostate CA
	HEALTH CARE PROVIDER (HCP)		
	ADDRESS OF HCP		
	SE D	X Male 🏻 Female	
	2. PhilHealth ID Number		- 🗌
	B. MEMBER   Same as patient (Answer the following only if the patient is a dependent of the following of the following only if the patient is a dependent of the following of	ent)	A particular and the second se
	2. PhilHealth ID Number	164	-
62)	PRE-AUTHORIZATION CHECKLIST Prostate Cancer		
TER PY Date: (2/2/	Fulfilled selections criteria  Yes If yes, proceed to pre-authoriz  No If no, specify reason/s and en	ation app code	plication
MASTER COPY	ATTESTED BY ATTENDING PHYSICIAN	(Pl	ace a √if YES)
30/2	QUALIFICATIONS		YES
2	No previous radiotherapy for prostate cancer		
	No uncontrolled co-morbid conditions		
20		(Pl	ace a √if YES)
	DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
	(T1a-T3c), Tumor Grade (Gleason's score of 6-9)		7777
	No evidence of metastasis (documented by <u>any</u> of the following):  ☐ Bone scan ☐ Pelvic CT/MRI ☐ PET Scan		
	(Attach results to the patient's chart)		
	Conforme by Patient/Guardian: Certified correct by	y Attendir	ng Physician:
	Printed name and signature  Printed name and signature  PhilHealth Accreditation No.	me and si	gnature





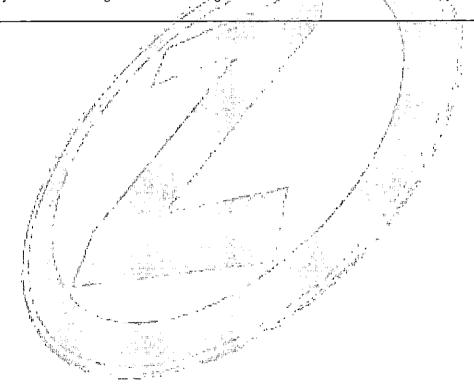


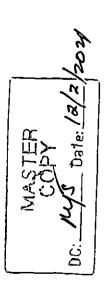
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#### Note:

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

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









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#### PRE-AUTHORIZATION REQUEST **Prostate Cancer**

DATE OF REQUEST (mm/dd/yyyy):							
This is to request approval for provision of services under the Z benefit package for							
		in	·				
(Patient's last, first, suffix, middle under the terms and conditions		l for ava	(Name of <i>HCP</i> ) ilment of the Z Benefit Package.	To a supply of the supply of t			
The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):    Without co-payment   With co-payment, for the purpose of:							
Certified correct by:							
(Printed name and signature)  Attending Surgeon  Attending Medical Oncologist							
PhilHealth Accreditation No.					-		
Conforme by:							
(Printed name and sign	(Printed name and signature)  Executive Director/Chief of Hospital/  Medical Director/ Medical Center Chief  Chill Leath  Locreditation No.						
(For PhilHealth Use Only)  □ APPROVED □ DISAPPROVED (State reason/s)							
(Printed name and signature Head or authorized representative, Be	) enefits A	- dministr	ation Section (BAS)				
INITIAL APPLICAT			COMPLIANCE TO REQ	UIREME	NTS		
Activity Received by LHIO/BAS:	Initial	Date	☐ APPROVED ☐ DISAPPROVED (State reason	on/s)			
Endorsed to BAS (if received by LHIO):			(Printed name and signature) Head or authorized BAS representative				
☐ Approved ☐ Disapproved			Activity	Initial	Date		
Released to HCP:	_		Received by BAS:				
This pre-authorization is valid for	☐ Approved ☐ Disapproved						
calendar days from date of approval of request.			Released to HCP:	1			







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Case No							
	Annex	"A-TOF"					
HEALTH CAI	RE PROVIDER (HCP)						
ADDRESS OF	FHCP						
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix  SEX  Male	le 🏻 Female					
	2. PhilHealth ID Number	<u> </u>					
B. MEMBER	Same as patient (Answer the following only if the patient is a dependent)						
1	1. Last Name, First Name, Middle Name, Suffix						
	2. PhilHealth ID Number						
		*.  -					
runned sele	Fulfilled selections criteria  Yes If yes, proceed to pre-authorization application  No If no, specify reason/s and encode						
	PRE-AUTHORIZATION CHECKLIST  Tetralogy of Fallot Surgery						
	S. A. W. C. C. C. C. C. C. C. C. C. C. C. C. C.	eck mark (✓)					
QUALIFICA'		YES					
Age 1 to 10 year	ars and 364 days						
ATTESTED	BY ATTENDING PEDIATRIC CARDIOLOGIST						
<u> </u>	Place a ch	eck mark (🗸)					
QUALIFIÇA.		YES					
1. Check past	history:						
	a. No previous cardiac surgery or intervention such as BTS (Blalock						
Taussig Shunt) b. No PDA Stenting or							
	residual VSD from previous open heart surgery for total correction						
	sical examination:						
	patomegaly or						
	ema lower extremities  iital chromosomal abnormalities or other congenital defects, except						
	1 (Down's syndrome)						



Place a check mark (V)

	T lace a	CHECK HAIR (* )
DIAGNOSTICS <sup>1</sup>	YES	DATE DONE
		(mm/dd/yyyy)
Based on the results of 2D Echocardiogram OR, if applicable,	'	
cardiac catheterization OR CT angiogram: <sup>2</sup>	*****	
a. Confirmed Tetralogy of Fallot OR Confirmed Ventricular		
Septal Defect and pulmonic stenosis, severe (This is similar		•
to TOF morphology) <sup>3</sup>	* , , ; ,	in the second se
b. No other associated congenital heart disease (CHD) that		•
includes the following:	3	
i. absent pulmonic valve	\$ .*	•
ii. pulmonary valve atresia	,	<u>.</u>
ii. atrioventricular septal defect (AVSD)		ì
c. Confluent and adequate pulmonary artery sizes OR	1	
acceptable pulmonary valve annulus	į	
d. NO major aorto-pulmonary collateral arteries (MAPCA's)		

Must be done at least within one fiscal (1) year from date of receipt of pre-authorization.

<sup>2</sup> Attach OFFICIAL 2D ECHO RESUL'IS in the patient's chart

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

i. VSD Patch Closure

ii. + RVOT repair with or without patch OR

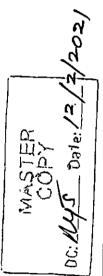
iii. + infundibulectomy of the infundibular muscle

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

#### Note:

Once approved, the contracted HCP 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.



Page 2 of 3 of Annex A - TOF



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### PRE-AUTHORIZATION REQUEST Tetralogy of Fallot Surgery

DATE OF REQUEST (mm/c	ld/yyyy)	:		_		
This is to request approval for	provisio	n of serv	vices under the Z benefit packag	e for		
		;	A STATE OF THE PARTY OF THE PAR			
			n O I Criev	*		
(Patient's last, first, suffix, mid		od for an	(Name of <i>HCI</i> ) ailment of the Z Benefit Packag			
dider the terms and conditions	s as agre	eu ioi av	amment of the v Deneric Lackas	C. 3/		
The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):    Without co-payment   With co-payment, for the purpose of:						
- 'An' - 'An'	' -			1 11		
Certified correct by:						
(Printed name and sig	nature)		(Printed name and s			
Please tick appropriate box	and the same of th	131	Executive Director/Chie	f of Hosp	oital/	
☐ Chair, Department of Pedia	atric Car	diology	Medical Director/ Medic	al Center	Chief	
☐ Chief, Division of Pediatric	CV Su	gery				
Phill-lealth Accreditation No Phill-lealth Accreditation No						
(A) (A) (A) (A) (A) (A) (A) (A) (A) (A)						
			Conforme by:			
		The same of the sa	(Printed name and	signature)		
The state of the s	7907	er.	Patient			
A Control of the Cont		DL:ILJ	alth Use Only)			
T ADDROVED	(ĽO	гишпе	aith Ose Only)			
☐ APPROVED	/-					
☐ DISAPPROVED (State rea	ason/s)					
(Printed name and signatur	ഘ					
Head or authorized representative, I		Adminis	tration Section (BAS)			
INITIAL APPLICAT			COMPLIANCE TO REQ	UIREME	NTS	
Activity	Initial	Date	☐ APPROVED			
Received by LHIO/BAS:			☐ DISAPPROVED (State reaso	n/s)		
		_	1	•	1	
Endorsed to BAS	,					
(if received by LHIO):		(Printed name and signa		i		
Approved Discoursed			Head or authorized BAS rep	Initial	Date	
☐ Approved ☐ Disapproved			Activity	muai	Date	
Released to HCP:		. 1	Received by BAS:			
This pre-authorization is valid for one hundred    Approved   Disapproved						
eighty (180) calendar days from date of approval			Released to HCP:			



Revised as of November 2021

Page 3 of 3 of Annex A - TOF



Republic of the Philippines

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	www.pnimeann.gov.pn		UNIVERSAL 1
	Case No	Annex '	"A1 VSD"
	HEALTH CARE PROVIDER (HCP)		
	ADDRESS OF HCP		
	A. PATIENT 1. Last Name, First Name, Middle Name, Suffix	SEX	·   Female
	2. PhilHealth ID Number		<u> </u>
	B. MEMBER		
	2. PhilHealth ID Number	,	<u> </u>
	Fulfilled selections criteria Yes If yes, proceed to pre-authorization. In No If no, specify reason/s and encode PRE-AUTHORIZATION CHECKLIST	le	
•	Ventricular Septal Defect (VSD) Closure	Place a ch	eck mark (✔)
_	QUALIFICATIONS	ŗ.	YES
	Age 1 to 10 years and 364 days		
	ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST	Place a che	eck mark (✔)
			DATE DONE (mm/dd/yy)
	Based on 2D Echiocardiogram. <sup>2</sup> a. Confirmed ventricular septal defect perimembranous, subaortic or subpulmonic, or inlet type		
	b. NO combined shunts such as atrial septal defect or atrioventricular septal defect, <i>Aortopulmonary window</i>		
ل	c. NO other associated congenital heart disease (CHD): such as coarctation of the aorta, or moderate to severe aortic insufficiency needing replacement		•
	d. NO unstable congenital anomalies		
	e. Pulmonary artery maximum systolic pressure gradient  <55mmHg or pulmonary valve annulus with a Z score of -1 to +1		
	f. Pulmonary arterial pressure (PAP) normal, mild to moderate or less than 2/3 the systolic blood pressure, with hemodynamic studies, if applicable		



<sup>&</sup>lt;sup>1</sup> Must be done at least within six (6) months from date of receipt of pre-authorization <sup>2</sup> Attach OFFICIAL 2D ECHO RESULTS in the patient's chart

	PE DROIADER (UCD)	<del></del>				
HEALTH CARE PROVIDER (HCP)						
ADDRESS OF	ADDRESS OF HCP					
A. PATIENT	1. Last Name, First Name, Mide					
ist the side	<del></del>	☐ Male ☐ Female				
er julius est	2. PhilHealth ID Number					
B. MEMBER	☐ Same as patient (Answer, the follow.					
	1. Last Name, First Name, Mide	dle Name, Suffix				
	2. PhilHealth ID Number					
Certified correc	t by:	Conforme by:				
		<b>₽</b>				
(D.:-	nted name and signature)	(Printed name and signature)				
	ling Pediatric Cardiologist	Parent/Guardian				
PhilHealth Accreditation No.						
Section Section	A CONTRACTOR OF THE CONTRACTOR					
Note:						
Once approved, the contracted HCP 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:						
		wever, these should be included in the patient's chart				
and may be che	ecked during the Held monitoring of	the Z Benefits. Please do not leave any item blank.				
	T					





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### PRE-AUTHORIZATION REQUEST Ventricular Septal Defect (VSD) Closure

DATE OF REQUEST (mm/c	DATE OF REQUEST (mm/dd/yyyy)					
This is to request approval for	This is to request approval for provision of services under the Z benefit package for					
		:	••			
(Patient's last, first, suffix, mid	idle name	1	n(Name of <i>HCF</i>	<u> </u>		
under the terms and conditions	s as agre	ed for av	ailment of the Z Benefit Packag			
				١.		
	lth policy	on co-payn	nent and agreed to avail of the benefit	package (p	lease tick	
appropriate box):	en "	A James Market		. :		
□ Without co-payment			,	,		
☐ With co-payment, for the purpos	se oj:	- * .				
Certified correct by:		3	Certified correct by:	- : :		
Certified correct by:		يُنْمُو ما الله الله الله الله الله الله الله ال	Commed confect by:	. 47		
	, si					
(Printed name and sig	mature)	•	(Printed name and s			
Please tick appropriate box		##.	Executive Director/Chie			
☐ Chair, Department of Pedia			Medical Director/ Medical	al Center	Chief	
☐ Chief, Division of Pediatric	CV Sur	gery			<del>, , , , , , , , , , , , , , , , , , , </del>	
PhilHealth Accreditation No.					_	
			,			
		1	Conforme by:			
	inst .	*	,			
			(Printed name and signature)			
,		~	Patient			
, s	/E =	DL:IT:T-				
	(ro	r it minties	alth Use Only)			
☐ APPROVED		- 1				
☐ DISAPPROVED (State re	ason/s) .					
(D: 1 1:	`					
(Printed name and signatur	rej Romofia-	م استامهٔ	emtion Coation (PAC)			
Head or authorized representative, ]		rumiiisi	<u> </u>			
INITIAL APPLICAT			COMPLIANCE TO REQ	UIREME	NTS	
Activity	Initial	Date	☐ APPROVED	(a)		
Received by LHIO/BAS:			☐ DISAPPROVED (State reaso	III/S)		
Endorsed to BAS  (Printed name and signature)						
(if received by LHIO):  Head or authorized BAS						
☐ Approved ☐ Disapproved			Activity	Initial	Date	
Released to HCP:			Received by BAS:	<u> </u>		
This pre-authorization is valid fo			☐ Approved ☐ Disapproved			
eighty (180) calendar days from do of request.	eighty (180) calendar days from date of approval					



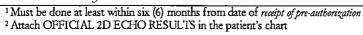
Page 3 of 3 of Annex A1 - VSD



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Case No			RAUSBERAN AS MAI
		Ann	ex "A2 – VSD"
HEALTH CAR	E PROVIDER (HCP)		
ADDRESS OF	HCP	And the same of th	
A PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX	fale ↓ □ Female
	2. PhilHealth ID Number	]-[]	T CHIAC
B. MEMBER	Same as patient (Answer the following only if the patient is a dependen 1. Last Name, First Name, Middle Name, Suffix	<i>t</i> )	
	2. PhilHealth ID Number		411
		3	matri)
Fulfilled s	relections criteria		plication
Ventric	PRE-AUTHORIZATION CHECKLIST lar Septal Defect (VSD) Closure with Associated Special C		onditions a check mark (✔)
QUALIFICAT	IONS		YES
Age 1 to 10 year	s and 364 days		
ATTESTED B	Y ATTENDING PEDIATRIC CARDIOLOGIST	D11	.11.(0
		Place a ch	eck mark (√) DATE
	DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
a. Confirmed	Echocardiogram: <sup>2</sup> ventricular septal defect perimembranous, subaortic, ic, <i>or inlet type</i>		
	ned shunts such as atrial septal defect or atrioventricular septal o-pulmonary window		
c. NO LV Ou	uflow tract obstruction (CHD): such as coarctation of the		
	following may be allowed:		
	ed patent ductus arteriosus		
Moderate	aortic insufficiency not warranting replacement		
	ary or Artery Pressure > 2/3 of systemic pressure with reactive ary bed by ECHO documented by cardiac catheterization		





Down's Syndrome

		•			
HEALTH CAR	E PROVIDER (HCP)				
ADDRESS OF	HCP				
A.PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX  Male  Female			
	2. PhilHealth ID Number				
B, MEMBER	☐ Same as patient (Answer the following only if the patient is a  1. Last Name, First Name, Middle Name, Suffix	a dependent)			
	2. PhilHealth ID Number				
Certified correct	by: Conforme by:				
		ed name and signature) Parent/Guardian			
PhilHealth Accreditation No.					
	d, the contracted HCP shall print the approved pre-a				
submitted to t when filing the	submitted to the Local/Health Insurance Office (LHIO) or the PhilFlealth Regional Office (PRO) when filing the first tranche.				
	There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.				
*		/			







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

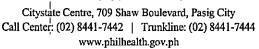
						<del></del>
	DATE OF REQUEST (mm/dd/yyyy)					
	This is to request approval for	provisio		rices under the Z benefit packag	e for	
	(Patient's last, first, suffix, mi	iddle name) s as agre		m (Name of <i>HCI</i> ailment of the Z Benefit Packag	e	
	The patient is aware of the PhilHed appropriate box):  Without co-payment  With co-payment, for the purpo	23	on co-payn	nent and agreed to avail of the benefit	package (t	lease tick
	Certified correct by:	,		Certified correct by:		
	(Printed name and sig Please tick appropriate box ☐ Chair, Department of Pediatr ☐ Chief, Division of Pediatric C	ic Cardio		(Printed name and s Executive Director/Chie Medical Director/ Medical	f of Hospi	tal/ Lhief
1202/	Phill-lealth Accreditation No.			Phill-lealth Accreditation No.		
TER PY 0a1e: (2/2)				David James	oiamat um)	
نف ک	(Printed name and signature) Patient/Parent/Guardian					
世入る		اد شد. - حادث دا چار سمیسسی		1 along latenty		]
\$ 100 kg	□ APPROVED	#ก็กำละ วิบลุสทางการั	or PhilHe	alth Use Only)		
5 \$	☐ DISAPPROVED (State reason	on/s)	web., Virginia Pr			
50	(Printed name and signature) Head or authorized representative, Ber		ministratio	on Section (BAS)		
	INITIAL APPLICAT	TION		COMPLIANCE TO REQ	UIREME	NTS
	Activity	Initial	Date	☐ APPROVED	OHELIVIE	
	Received by LHIO/BAS:			☐ DISAPPROVED (State reaso	n/s)	
Endorsed to BAS (if received by LHIO):			- (Printed name and signo Head or authorized BAS rej			
	☐ Approved ☐ Disapproved			Activity	Initial	Date
	Released to HCP:			Received by BAS:		
	This pre-authorization is valid for one hundred			☐ Approved ☐ Disapproved		
	eighty (180) calendar days from date of approval of request.			Released to HCP:		





#### Republic of the Philippines

#### PHILIPPINE HEALTH INSURANCE CORPORATION





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.
- 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
  - 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.
- Dalawang kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente at sa ospital. Duplicate copies of the ME form shall be made available by the contracted HCI—one for the patient and one as file copy of the contracted HCI providing the specialized care.
- 7. Para sa mga pasyenteng gagamit ng Z Benefit for Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, o Z Benefits para sa mga batang may kapansanan, 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 lower limb prosthesis, or Z Benefits for children with disabilities, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

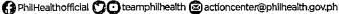
PANGALAN NG OSPITAL	
HEALTH CARE INSTITUTION	(HCI)

ADRES NG OSPITAL ADDRESS OF HCI









	1200
MASTER	45_ Date: 12/
	DC: //

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 PASYE	NIE 🗆 🗆 🗆 🗆 🖂					
PHILHEALTH ID NUMBER OF PATIENT MIYEMBRO (kung ang pasyente ay kalipikado	ong makikinabang) (Apelyido, Pa	ngalan, Panggitnang Apelyido, Karagdagan sa				
Pangalan) MEMBER (if patient is a dependent) (Last name, First						
NUMERO NG PHILHEALTH ID NG MIYEM	BRO     -					
PHILHEALTH ID NUMBER OF MEMBER PERMANENTENG TIRAHAN						
PERMANENT ADDRESS	r grander grander	e e				
Petsa ng Kapanganakan (Buwan/ Araw/Taon)  Birthday (mm/ dd/3333)	Edad Age	Kasarian Sex				
Numero ng Telepono Telephone Number	Numero ng Cellphone  Mobile Number	Email Address  Email Address				
Kategorya bilang Miyembro:	Ivioute i vamoet	Limas 2 total 633				
Membership Category:	<u> </u>					
Direct contributor						
Direct contributor	•					
☐ Empleado ng pribadong sector	☐ Kasambaha	y / Household Help				
Employed private		o ng Pamilya/ Family driver				
☐ Empleado ng gobyerno		Manggagawa sa ibang bansa				
Employed government  May sariling pinagkakakitaan	Migrant Wo □ Land-b					
Self earning pinagkakaknaan	Land-ba					
☐ Indibidwal		ay na kaanib/ <i>Lifetime Member</i>				
Individual		may dalawang pagkamamamayan/Nakatira				
☐ Sole proprietor	sa ibang b					
Sole proprietor		h Dual Citizenship/Living abroad				
Group enrollment scheme  Group enrollment scheme	Li Foreign nat	ional/Foreign national				
Group encouncie science						
Indirect contributor Indirect contributor						
☐ Listahanan	☐ Inisponsura	n ng I.GU				
Listahanan	LGU-sponso	<u> </u>				
☐ 4Ps/MCCT	☐ Inisponsura					
_ 4Ps /MCCT	NGA-sponso					
□ Nakatatandang mamamayan		ın ng pribadong sector				
Senior Citizen (RA 10645)  PAMANA	Private-spons ☐ Taong may	_				
PAMANA	Person with					
□ KIA/KIPO						
KLA/KIPO						
☐ Bangsamoro/Normalization						



	B. Impormasyong Klinikal <i>B. Clinical Information</i>	
	1. Paglalarawan ng kondisyon ng	<u> </u>
	pasyente	
	Description of condition	
$\vdash$	2. Napagkasunduang angkop na plano	<del>-</del>
'		
	ng gamutan sa ospital	
	Applicable Treatment Plan agreed upon	
	with healthcare provider	
$\vdash$	3. Napagkasunduang angkop na	
'	3. Napagkasunduang angkop na alternatibong plano ng gamutan sa	
ì	ospital	
ı	Applicable alternative Treatment Plan	
6	agreed upon with health care provider	J V J
	C. Talatakdaan ng Gamutan at Kasuno	
	C. Treatment Schedule and Follow-u	p Visit/s
	Petsa ng unang pagkakaospital o	
	konsultasyon a	
	(buwan/araw/taon)	
	Date of initial admission to HCI or 🦯	
	consulta (mm/dd/yyyy)	
	Para sa ZMORPH/ mga batang may kapansanan, no ay tumutukoy sa pagkonsulta	
	para sa rehabilitasyon ng external lower limb	
	pre-prosthesis/ device. Para naman sa PD First,	Segregation of the Control of the Co
	no ay ang petsa ng konsultasyon o pagdalaw sa PD provider bago magsimula ang unang PD	
	exchange.	
	For ZMORPH/shildren with disabilities (CWDs),	
	this refers to the consult prior to the provision of the device and/or rehabilitation. For PD First, this refers to	e vit
	the date of medical consultation or visit to the PD	mp <sup>a, ACT</sup>
	Provider prior to the start of the first PD exchange.	•
$\vdash$	2 Degradado Data de accionad	
	2. Pansamantalang Petsa ng susunod	
	na pagpapa-ospital o konsultasyon <sup>b</sup> (buwan/araw/taon)	
1		
	Tentative Date/s of succeeding admission to HCI or consult (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	
$\vdash$	Provider. 3. Pansamantalang Petsa ng kasunod	
'	3. Pansamantalang Petsa ng kasunod na pagbisita (buwan/araw/taon)	
	Tentative Date/s of follow-up visit/s	
	(mm/ dd/ yyyy)	
	(mm/ aa/ yyyy)  c Para sa ZMORPH/ mga batang may	
	kapansanan, ito ay tumutukoy sa rehabilitasyon	
	ng external lower limb post-prosthesis.	
	For ZMORPH/CWD, this refers to the external lower limb post-prosthesis rehabilitation consult.	
- 1		



	<b>▼</b>	1202/
HE SAM	COPY.	06: Mys Date: (2/2)

D. Edukasyon ng Miyembro D. Member Education		
Lagyan ng tsek (V) ang angkop na sagot o NA kung hindi nauukol Put a check mark (V) opposite appropriate answer or NA if not applicable.	⊒00 • . 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/interventiond.  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.	5 4 W	
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.	N.	
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	ÖO	HINDI
Put a check mark() opposite appropriate answer of NA if not applicable.	YES	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. Givil 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 Nikipun ala an Irana na lisaka an Irana		<del> </del>
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa		
karampatang paggagamot ng aking kondisyon o karamdaman.	3.00 361	
I have been furnished by my health care provider with a list of other contracted HCIs for the	4-2.	
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 Phill-Lealth 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 oriteria 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.		
The state of the s		
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.		
		ļ
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		



	discharge from the hospital)
e	. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito,
	babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth
	I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth
	benefits
f	Pumapayag akong magbayad ng hanggang sa halagang PHP*
	para sa:
	I agree to pay as much as PHP* for the following:
	□ Paglipat ko sa mas magandang kuwarto, o
	I choose to upgrade my room accommodation, or
	□ anumang karagdagang serbisyo, tukuyin
	additional services, specify
	* Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang
	kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng
	kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth.
	This is an estimated amount that guides the patient on how much the out of pocket may be
	and should not be a basis for auditing claims reimbursement.
_	The following are applicable to formal and informal economy and their qualified dependents  3. 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.
1	n. Pumapayag akong magbayad ng hanggang sa halagang PHP*
1	para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth.
	I agree to pay as much as PHP* as additional payment on top of my
	PhilHealth benefits.
	* Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang
ì	kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng
	kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth.
	This is an estimated amount that guides the patient on how much the out of pocket may be
	and should not be a basis for auditing claims reimbursement.
	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

d. Sakaling ako ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan o tumanggap ng karagdagang serbisyo na hindi kasama sa benepisyo, 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

In case I choose to upgrade my room accommodation or avail of additional services that are not included in the benefit package, 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

pagkalabas ng pagamutan)

Page 6 of 8 of Annex B - ME Form

the duration of my treatment/intervention under the Z Benefits.

E. Member Roles and Responsibilities	67.447.9	
Lagyan ng (v) ang angkop na sagot o NA kung hindi nauukol	-00	#HINDI
Put a (N) opposite appropriate answer or NA if not applicable.	YES	MNO.
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.	- 1	
I understand that adherence to my treatment schedule is important in terms of clinical outcomes	96.	
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	3.00	
PhilHealth at ospital upang magamit ang buong Z benefit package. Kung sakali na	lan 197	
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	5 8 70 *	
event that I fail to comply with policies and procedures of PhilHealth and the health care	l de grif	
provider, I waive the privilege of availing the Z benefits.		
	n. Z	
	•	
F. Pangalan, Lagda, Thumb Print at Petsa		

	1. Langaran, Lagua, Lindino I fintati etsa	
	F. Printed Name, Signature, Thumb Print and Date	
<b>\</b>	Pangalan at Lagda ng pasyente:*	Thumb Print
Š)	Printed name and signature of patient*	(kung hindi makakasulat
<i>, b</i>		ang pasyente) (if patient is unable to write)
·		ty patient is unable to write)
201	*Para sa mga menor de edad, ang magulang o tagapag-alaga ang	4. "
	pipirma o maglalagay ng thumb print sa ngalan ng pasyente.	
	* For minors, the parent or guardian affixes their signature or thumb print here	
ا نها ۲۵۰	on behalf of the patient.	
PY PY Date:	•	
		_
1 1000	Pangalan at lagda ng nangangalagang Doktor:	
350 P	Printed name and signature of Attending Doctor	
5 3		
7 21	Mga Saksi:	
1 1	Witnesses:	
) g	Pangalan at lagda ng kinatawan ng ospital:	
' <u>ā</u>	Printed name and signature of HCI staff member	
<del></del> J	Pangalan at lagda ng asawa/ magulang / pinakamalapit na	a kamag-
	anak/awtorisadong kinatawan	<b>o</b>
		onian d according on
	Printed name and signature of spouse/ parent/ next of kin / author	nizea guaraian or

E. Tungkulin at Responsabilidad ng Miyembro





representative

☐ walang kasama/ no companion

Petsa (buwan/ araw/ taon)

Petsa (buwan/araw/taon) Date (mm/dd/yyy)

Petsa (buwan/araw/taon) Date (mm/dd/yyyy) Petsa (buwan/araw/taon)

Date (mm/dd/yyyy)

Numero ng Telepono Telephone number	Numero ng Cell Mobile number	Phone	Email A	Address
<del></del> -		and the second s	ACOUNT TO THE PERSON OF THE PE	and the state of t
H. Numerong maaaring tawaga	nn sa PhilHealth	<u> </u>		
H. PhilHealth Contact Details Opisinang Panrehiyon ng PhilHea	th		ا الالي	
PhilHealth Regional Office No.			•	
Numero ng telepono				
Hotline Nos.				Section 1
gg & room				
l. Pahintulot sa pagsusuri sa talaar		J. Pahintulot	na mailagay:	ang medical data sa Z
I. Consent to accèss patient re	cord	benefit inform	nation and tr	acking system (ZBITS
		Ť Canana i		dical data in the Z
		J. Consent to	o enterme matian ka	dical data in the Z tracking system
			ппанон ос.	Hacking system
Also ay numanayahana suriin na Pl	ulHealth and aking	(ZBITS)		
Ako ay pumapayag na suriin ng Phalaang medikal mang manatunay	ull lealth ang aking	(ZBITS) Ako ay puma	payag na ma	ilagay ang aking
Ako ay pumapayag na suriin ng Phalaang medikal upang mapatunay ng Z-claim	uilFlealth ang aking an ang katotohanan	(ZBITS) Ako ay puma impormasyon	payag na ma g medikal sa	ilagay ang aking i ZBITS na kailangan s
talaang medikal upang mapatunay ng Z-claim	in ang katotohanan.	Ako ay puma impormasyon benefits. Pina	payag na ma g medikal sa shihintulutar	ilagay ang aking i ZBITS na kailangan s i ko din ang PhilFlealtl
talaang medikal upang mapatunay ng Z-claim I consent to the examination by PhilHe	an ang katotohanan. alth of my medical	(ZBITS) Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga	payag na ma g medikal sa shihintulutar g aking pers n sa mga kin	ilagay ang aking a ZBITS na kailangan s a ko din ang PhilHealtl onal na impormasyong contratang ospital.
talaang medikal upang mapatunay ng Z-claim	an ang katotohanan. alth of my medical	(ZBITS) Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to haw	payag na ma g medikal sa shihintulutar g aking pers n sa mga kin e my medical d	ilagay ang aking ZBITS na kailangan s i ko din ang PhilHealtl onal na impormasyong ontratang ospital. lata entered electronically in
talaang medikal upang mapatunay ng Z-claim I consent to the examination by PhilHe records for the sole purpose of verifying th	an ang katotohanan. alth of my medical	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to baw ZBITS as a rec	payag na ma' g medikal sa shihintulutar g aking pers n sa mga kin e my medical d quirement for t	ilagay ang aking i ZBITS na kailangan s i ko din ang PhilF-lealtl onal na impormasyong ontratang ospital. lata entered electronically in the Z Benefits. I authorize
talaang medikal upang mapatunay ng Z-claim I consent to the examination by PhilHe records for the sole purpose of verifying th	an ang katotohanan. alth of my medical	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to hav ZBITS as a rea PhilHealth to a	payag na ma g medikal sa ahihintulutar g aking pers n sa mga kin e my medical d quirement for thisclose my pers	ilagay ang aking ZBITS na kailangan s i ko din ang PhilHealtl onal na impormasyong ontratang ospital. lata entered electronically in
alaang medikal upang mapatunay ng Z-claim I consent to the examination by PhilHe records for the sole purpose of verifying th	an ang katotohanan. alth of my medical	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to baw ZBITS as a rec	payag na ma g medikal sa ahihintulutar g aking pers n sa mga kin e my medical d quirement for thisclose my pers	ilagay ang aking i ZBITS na kailangan s i ko din ang PhilF-lealtl onal na impormasyong ontratang ospital. lata entered electronically in the Z Benefits. I authorize
calaang medikal upang mapatunay ng Z-claim I consent to the examination by PhilHe records for the sole purpose of verifying the claim	an ang katotohanan alth of my medical ne veracity of the Z-	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to have ZBITS as a rea PhilHealth to a contracted partn	payag na ma g medikal sa ahihintulutar g aking pers n sa mga kin e my medical d quirement for this close my pers ers	ilagay ang aking a ZBITS na kailangan s a ko din ang Phill-lealtl onal na impormasyong ontratang ospital. lata entered electronically in the Z Benefits. I authorize onal health information to
calaang medikal upang mapatunay, ng Z-claim I consent to the examination by PhilHece records for the sole purpose of verifying the claim  Ako ay nagpapatunay na walang p	an ang katotohanan alth of my medical ne veracity of the Z ananagutan ang Phil	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to hav ZBITS as a rec PhilHealth to a contracted partn	payag na ma g medikal sa ahihintulutar g aking pers n sa mga kin e my medical d quirement for this close my pers ers	ilagay ang aking a ZBITS na kailangan s a ko din ang Phili-lealtl onal na impormasyong contratang ospital. lata entered electronically in the Z Benefits. I authorize conal health information to
ralaang medikal upang mapatunay ng Z-claim I consent to the examination by PhilHea records for the sole purpose of verifying the claim  Ako ay nagpapatunay na walang p mula sa pahintulot na nakasaad sa	an ang katotohanan alth of my medical ne veracity of the Z ananagutan ang Phil	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to hav ZBITS as a rec PhilHealth to a contracted partn	payag na ma g medikal sa ahihintulutar g aking pers n sa mga kin e my medical d quirement for this close my pers ers	ilagay ang aking a ZBITS na kailangan s a ko din ang Phili-lealtl onal na impormasyong contratang ospital. lata entered electronically in the Z Benefits. I authorize conal health information to
calaang medikal upang mapatunay, ng Z-claim  I consent to the examination by PhilHearecords for the sole purpose of verifying the claim  Ako ay nagpapatunay na walang p mula sa pahintulot na nakasaad sa benefits ng PhilHealth.	an ang katotohanan alth of my medical ne veracity of the Z- ananagutan ang Phil itaas sapagkat kusan	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to baw ZBITS as a rec PhilHealth to a contracted partn Health o sinum g-loob ko itong	payag na ma' g medikal sa sahihintulutar g aking pers n sa mga kin e my medical d quirement for t isclose my pers ers ang opisyal, i ibinigay upa	ilagay ang aking a ZBITS na kailangan s a Ko din ang PhilF-lealth onal na impormasyong ontratang ospital. lata entered electronically in the Z Benefits. I authorize onal health information to empleyado o kinatawa ang makagamit ng Z
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alaang medikal upang mapatunay, ng Z-claim  I consent to the examination by PhilHear records for the sole purpose of verifying the claim  Ako ay nagpapatunay na walang p mula sa pahintulot na nakasaad sa benefits ng PhilHealth.  I hereby hold PhilHealth or any of its of the berein-mentioned consent which I have ver the philHealth.  Buong pangalan at lagda ng pasyer Printed name and signature of patient*  Para sa mga menor de edad, ang magula maglalagay ng thumb print sa ngalan ng p  For minors, the parent or guardian affixes the of the patient.	an ang katotohanan ang hil ananagutan ang Phil itaas sapagkat kusan fficers, employees and/or oluntarily and willingly and or ang o tagapag-alaga ang pasyente.  Ir signature or thumb print be katawan sa pasyente	Ako ay puma impormasyon benefits. Pina maipaalam an pangkalusuga I consent to have ZBITS as a receptive phi/Health to a contracted partner gloob ko itong representatives frequiven in connection.  The confidence of the confidence	payag na mag g medikal sa ahihintulutar g aking persen sa mga king persen sa mga king medical danirement for this close my persers and opisyal, a ibinigay upage from any and with the Z closumb print ung hindi na nakasusulat) autient is unable	ilagay ang aking a ZBITS na kailangan sa ko din ang PhilHealth onal na impormasyong ontratang ospital. Idata entered electronically in the Z Benefits. I authorize onal health information to empleyado o kinatawa ang makagamit ng Z d all liabilities relative to taim for reimbursement before  Petsa (buwan/araw/ta Date (mm/dd/yyyy)





Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 Trunkline: (02) 8441-7444 www.philhealth.gov.ph



Case No.

Annex "C1-ALL"

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

#### Tranche 1

		HEALTH CAI	RE PROVIDER (HCP)	
		ADDRESS OF	FHCP	
		A. PATIENT	1. Last Name, First Name, Middle Name	Suffix  SEX  Male  Female
			2. PhilHealth ID Number	<b>5</b>
		B. MEMBER	☐ Same as patient (Answer the following only if the  1. Last Name, First Name, Middle Name	
			2. Phili-lealth ID Number	-
	_	DATE OF EN	ID OF INDUCTION PHASE (mm/dd/yyy	)
	202	Place a (V) in t	he appropriate tick box if the service is given	<u> </u>
	12	1 1	MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
	" X	A. Diagnostic	· · · · · · · · · · · · · · · · · · ·	
出入	Daie.	assessn	narrow aspirate examination (morphologic nent of BMA smears)	
Si	<u> </u>	□ CSF an	alysis with WBC differential count	
4 (	3/5	☐ CBC(v	vith platelet count)	
*_	3	☐ Alanine	e aminotransferase (ALT)	
	/ /5	☐ Bilirubi	n	
		☐ Creatin	ine	
		□ PT/PT	T	
		Electrolytes		
		☐ Soc	lium	☐ Calcium
		☐ Pot	assium	☐ Chloride
		And the second of the second o		☐ Magnesium ☐ Phosphorous/Phosphate
		7. · · · · · · · · · · · · · · · · · · ·		<u> </u>



Place a (1) in the appropriate tick box if the service is given

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
☐ Uric acid	☐ 2D echocardiography
☐ Chest X-ray	Flow cytometric immunophenotyping
	☐ CSF cytospin
	☐ Abdominal ultrasound
	☐ Evaluation of infection (ex. blood culture)
	☐ Others, indicate (ex.
	cytogenetics)
	Blood support and processing:
	☐ Blood typing
	☐ Cross matching
	☐ Blood screening
	☐ Blood products (packed RBC/ platelet concentrate/ fresh frozen plasma)
Complete list of medicines given	The state of the s
Chemotherapy	
Systemic	
prednisone or dexamethasone	
vincristine	
☐ <b>L</b> asparaginase	☐ doxorubicin
☐ Intrathecal	
☐ Single (methotrexate) OR	
☐ Triple (methotrexate, cytarabine, hydrocortisone)	
	Other drugs:
	☐ diphenhydramine
	☐ hydrocortisone
	Anti-emetics:
	☐ ondansetron
	☐ metoclopramide
	Pain medications:
	☐ nalbuphine
	☐ tramadol

00: My Date: 12/2/202

Page 2 of 3 of Annex C1 - ALL
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Place a  $(\checkmark)$  in the appropriate tick box if the service is given

	М	ANDA'	TORY S	OTHER SERVICES (As needed/ as indicated)			
<u>.</u>	, , , , , , , , , , , , , , , , , , ,		:	19629		2. 1. 1. 1.	Anesthetics:
			• 350°	CAN CAN			ketamine
			7.4			 9 ^	☐ propofol
							Sedatives (prior to procedure):
		3		, v	· •	¥	. 🗆 midazolam
			ينفاق				☐ diphenhydramine
73.2	* ** <u>.</u>		7	43	e de la companya de l	) ii	Antimicrobials:
÷.	. And		**************************************		1.5 m	1 21 A	☐ cotrimoxazole
					V No.	*	□ ceftriaxone
	i de la composition della comp	ý.		100		*,59°	☐ ceftazidime
			* 15% 15%	***	u, e		🗆 amikačin 🥻
		er Litte	* 1.				☐ antifungal (oral) specify,
						ed also	
		. 3	\$ <del>\$</del> .	- 1-			other <i>antimicrobials</i> based on hospital antibiogram specify,
* **			- 1	1. 1.0 [8]F.			inospicai antibiogram specify,
	**			. ,	· · · · ·		
		, <i>[</i>	agrae the not collect	·	age."		
Certified	l correct	by:				Conform	ie by:
_		10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	* **			, 2 <sup>m</sup>	
(Printed name and signature) Attending Physician				(Printed name and signature)			
Attending Physician PhilHealth			Date sign	Parent/Guardian ned (mm/dd/yyyy)			
l	Accreditation No.				Date sign	ica (iiiii) aa/ yyyyj	
Date sig	ned (mr ———	n/dd/yy 	/yy) 				

_		1202/
	MASTER COPY	00: /// Date: /a/2



Page 3 of 3 of Annex C1 - ALL

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Case No. \_\_\_\_\_

Annex "C2 - ALL"

### CHECKLIST OF MANDATORY AND OTHER SERVICES

Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk) Consolidation, Interim Maintenance and Delayed Intensification Phase

#### Tranche 2

		HEALTH CARE PROVIDER (HCP)	
		ADDRESS OF HCP	
		A PATIENT 1. Last Name, First Name, Middle Na	ne, Sulfix JEX D Male D Female
		2. PhilHealth ID Number	
		B. MEMBER   Same as patient CAnswer the following only in the sold of the sold	9.0 w/w/ 32 22 22 22 22 22 22 22 22 22 22 22 22
		2. PhilHealth ID Number	- 100 mm 1 mm 1 mm 1 mm 1 mm 1 mm 1 mm 1
	2	DATE OF END OF INTENSIFICATION OR RE-II	NDUCTION PHASE (mm/ dd/yyy)
	2	Place a (1) in the appropriate tick box if the service is give	
	12/	MANDATORY SERVICES	OTHER SERVICES (As needed/as indicated)
حہام	18	A. Diagnostics	
直沿	Da1e:/	□ CSF Analysis WBC differential count	☐ Bone marrow aspirate examination
NO NO NO		☐ CBC with platelet count	Alanine aminotransferase (ALT)
2	5	☐ Creatinine	PT/PTT
	5	□ Bilirabin	
	 00:	B. Complete list of medicines given	
		Chemotherapy	
		☐ Systemic	
		□ prednisone or dexamethasone	□ doxorubicin
		□ vincristine	☐ L-asparaginase
		□ cytarabine	
		☐ cyclophosphamide	
		☐ methotrexate (IV and oral)	
		☐ 6-mercaptopurine	
		☐ Intrathecal	
		☐ Single (methotrexate) OR	
		☐ Triple (methotrexate, cytarabine, hydrocortisone)	



Revised as of November 2021

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Place a (1) in the appropriate tick box if the service is given.

MANDATORY SERVICES	OTHER SERVICES
	(As needed/ as indicated) Other drugs
	U MESNA
	hydrocortisone
	Anti-emetics
	□ ondansetron
	☐ metoclopramide
	Antimicrobials
	□ cotrimoxazole \
	☐ ceftriaxone
The state of the s	□ ceftazidimė
	amikacin
	☐ antifungal (oral), specify '
	☐ Other antimicrobials based on
	hospital antibiogram
	Specify:
	3
	☐ Blood products
Certified correct by:	forme by: 27
(Printed name and signature)	(Printed name and signature)
Attending Physician	Parent/Guardian
Phill leath Accreditation No.	signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	
2	
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Daje: R	
F	





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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Case No.

Annex "C3 - ALL"

#### CHECKLIST OF MANDATORY AND OTHER SERVICES Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk) After 6th Maintenance Cycle

#### Tranche 3

		HEALTH CARE PROVIDER (HCP)	
		ADDRESS OF HCP	
		ADDICESS OF HCF	
		A. PATIENT   1. Last Name, First Name, Middle N	
			Male D Female
		2. PhilHealth ID Number	
		B. MEMBER   Same as patient (Answer the following on	
		1. Last Name, First Name, Middle N	Name, Suffix
		2./PhilHealth ID Number	
		DATE OF END OF 6th MAINTENANCE CYCLL	Timm   dd   www
	7/	Place a (1) in the appropriate tick box if the service is	given.
	8	MANDATORY SERVICES	OTHER SERVICES
	<u>,                                    </u>	A. Diagnostics	(As needed/ as indicated)
		2.28	Chest X-my
		☐ CSF Analysis WBC differential count	M. D Chest 21 1ay
Ϊ'	Date: <u>.</u>	☐ CBC with platelet count	☐ Bone marrow aspirate examination
<u> </u>	ê O		Alanine aminotransferase (ALT)
			☐ Creatinine
ءِ 'ر	21		☐ Bilirubin
Ž			☐ Amylase
	ပ္ပြဲ		☐ Cranial CT scan
			☐ CSF cytospin
			☐ Minimal residual disease by flow cytometry
		<u> </u>	· - · · · · · · · · · · · · · · · · · ·





Place a ( ) in the appropriate tick box if the service is given.

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)			
Complete list of medicines given				
Chemotherapy				
☐ Systemic				
☐ prednisone or dexamethasone	☐ doxorubicin			
□ vincristine				
☐ methotrexate (oral)				
☐ 6-mercaptopurine				
☐ Intrathecal				
☐ Single (methotrexate) OR				
☐ Triple (methotrexate, cytarabi hydrocortisone)	ne,			
	Anti-emetics			
	□ ondansetron			
	☐ metoclopramide			
	Antimicrobials			
	□ cotrimoxazole			
	□ ceftriaxone			
	□ ceftazidime			
	amikacin			
	antifungal (oral), specify			
	Other antibiotics based on			
	hospital antibiogram Specify:			
The state of the s	·			
	☐ Blood products			
Certified correct by:	Conforme by:			
-	_			
(Printed name and signature)	(Printed name and signature)			
Attending Physician	Parent/Guardian			
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)			
Date signed (mm/dd/yyyy)				





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Case No. \_

Annex "C1- Breast CA"

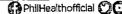
### CHECKLIST OF MANDATORY AND OTHER SERVICES

Early Breast Cancer Post-Surgery

#### Tranche 1

	HEALTH CARE PROVIDER (HCP)							
	ADDRESS OF	ADDRESS OF HCP						
						SEX		
	dije ay	2. PhilHealth ID Number		- ",		-		
2	B. MEMBER						ξ , ξ , τ	
	19 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2. PhilHealth ID Number		<u> -                                    </u>		t .	<u>l                                     </u>	
ρΥ Date/2/2/	Place a (✓) in t	he appropriate tick box			j	i ngà ng	<i>j</i>	
ا نوا		// MANDĄTORY SERVICE					Status	i
(6 B)	A. Procedure: (any one of the following):    Modified radical mastectomy					ity:		
00/2	□ Modified □ Total mas □ Partial m	radical mastectomy tectomy with sentinel lymph node biopsy astectomy of the breast/lumpectomy with				<i>i</i>   🗆	L breast	oreast
00: 45 CO	☐ Modified ☐ Total mas ☐ Partial m	radical mastectomy tectomy with sentinel lymph node biopsy astectomy of the breast/lumpectomy with		lymph node O	· biopsÿ ΓHER S	ERVIC	L breast bilateral l ES	oreast
200	☐ Modified ☐ Total mas ☐ Partial m	radical mastectomy tectomy with sentinel lymph node biopsy astectomy of the breast/lumpectomy with astectomy/lumpectomy of the breast with DATORY SERVICES		lymph node O	biopsý	ERVIC	L breast bilateral l ES	oreast
200	☐ Modified ☐ Total mas ☐ Partial m ☐ Partial m ☐ MAN ☐ B. Diagnostic	radical mastectomy tectomy with sentinel lymph node biopsy astectomy of the breast/lumpectomy with astectomy/lumpectomy of the breast with DAFORY SERVICES s: ography for all female 40 years old		lymph node O	· biopsÿ ΓHER S	ERVIC	L breast bilateral l ES	oreast
200	☐ Modified ☐ Total max ☐ Partial m ☐ Partial m ☐ MAN  B. Diagnostic ☐ Mamm and about  For feet (any of	radical mastectomy tectomy with sentinel lymph node biopsy astectomy with sentinel lymph node biopsy astectomy of the breast lumpectomy with astectomy lumpectomy of the breast with DAFORY SERVICES  S: ography for all female 40 years old we male, less than 40 years old of the following): Mammography		lymph node O	· biopsÿ ΓHER S	ERVIC	L breast bilateral l ES	oreast .
200	☐ Modified ☐ Total max ☐ Partial m ☐ Partial m ☐ MAN  B. Diagnostic ☐ Mamm and about  For feet (any of	radical mastectomy tectomy with sentinel lymph node biopsy astectomy with sentinel lymph node biopsy astectomy of the breast lumpectomy with astectomy lumpectomy of the breast with  DAFORY SERVICES  S: ography for all female 40 years old we male, less than 40 years old f the following): Mammography Ultrasound of breast and axillary bed		lymph node O	· biopsÿ ΓHER S	ERVIC	L breast bilateral l ES	oreast .
200	☐ Modified ☐ Total mas ☐ Partial m ☐ Partial m ☐ MAN  B. Diagnostics ☐ Mamma and about For feet (any of the control of the co	radical mastectomy rectorny with sentinel lymph node biopsy astectomy with sentinel lymph node biopsy astectomy of the breast lumpectomy with astectomy lumpectomy of the breast with  DATORY SERVICES  S: cography for all female 40 years old we male, less than 40 years old of the following): Mammography Ultrasound of breast and axillary bed patients and of both breasts and axillary bed athology		lymph node O	· biopsÿ ΓHER S	ERVIC	L breast bilateral l ES	Dreast







MANDATORY SERVICES

*		2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	☐ Chest X-ray PA and lateral views*
			☐ Alkaline phosphatase*
			☐ Ultrasound of whole abdomen*
	100 %1 40 80 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		□ ECG
			☐ -Creatinine
	e de la companya de la companya de la companya de la companya de la companya de la companya de la companya de La companya de la co		- □ PT/PTŢ
		i de la compansión de la compansión de la compansión de la compansión de la compansión de la compansión de la Compansión de la compansión de l	☐ CP clearance
			□ FBS
			Electrolytes*
	en en en en en en en en en en en en en e		□ Sodium
	. A Š.		D Potassium
			☐ Chloride
			☐ Calcium / Alling
		The state of the s	☐ Phosphate (1)
	**************************************	gradient de la companya de la compan	□ Urinalysis*
:			☐ 2D echo**
** ***********************************	1		□ SGPT*
			□ SGOT*
			Complete list of medicines given: (may
			attach a separate sheet)
*not required	for cStage 0 DCIS d for HER negative breast c	meer	
not required	d for Theix negative breast c	arcer	,
(O .'C 1		- 	
Certified c	correct by:	,	Certified correct by:
	Printed name and sign		(Printed name and signature)
PhilHealth	Attending Surgeo	n	Attending Medical Oncologist
Accreditation N		_	Accreditation No.
Date signe	ed (mm/dd/yyyy)		Date signed (mm/dd/yyyy)
	-		
			Conforme by:
			(Printed name and signature)
			Patient
		j	Date signed (mm/dd/yyyy)

OTHER SERVICES

as needed/as indicated

☐ CBC with platelet count\*





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Case No.

THE AT THE CARE DECIZIOED (LICE)

Annex "C2- Breast CA"

#### CHECKLIST OF MANDATORY AND OTHER SERVICES

Early Breast Cancer

Upon completion of one (1) month hormonotherapy or last cycle of chemotherapy for stages I-IIIA and upon completion of surgery for stage 0-IA not requiring chemotherapy

#### Tranche 2

ADDRESS OF	F HCP				
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix				
	☐ Male ☐ Female				remale
	2. PhilHealth ID Number				<u> </u>
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)  1. Last Name, First Name, Middle Name, Suffix				
	2. PhilHealth ID Number		] -		<b></b>
Place a (✓) in t	he appropriate tick box.	a La			,
MAN	DATORY SERVICES			ER SERVICES ated/as neede	
A. Histopatho	logic Stage (Indicate):		in grand		
	,				_
	ist of medicines given:				
	therapy (for ER+ BrCa):			*	
	noxifen x 5 years		letrozole x 5 y	vears	
	rapy* (any one of the following	<u> </u>		•	
treatment protocols):				,	
☐ Neo-adjuvant therapy —			*	·. 	.*:
☐ AC x 6 cycles			*		24 m Notation
doxorubicin/epirubicin*** for			• •		
patients with cardiac dysfunctions,					
	cyclophosphamide				. #
☐ CMF*** x 6 cycles			1 85 km		
cyclophosphamide, methotrexate, fluorouracil					

\*not required for Stage 0 DCIS

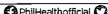
\*\* In order to achieve the expected pathological response of neoadjuvant therapy, the full 4 to 8 cycles of chemotherapy and anti-HER2 neu treatment if HER2+, depending on the protocol used, is given prior to surgery provided there is clinical response.

\*\*\*for elderly or those with heart disease who cannot tolerate doxorubicin; epirubicin can be given instead of doxorubicin in patients with history

of heart disease

\*Tamoxifen is given for ER+ BrCa after cytotoxic chemotherapy and can be given together with trastuzumab in pre- and post-menopausal patients; Letrozole cannot be given to premenopausal patients







MANDATORY SERVICES	other services s needed/as indicated			
☐ Docetaxel-Carboplatin (TCb) x 4 cycles For ER-HER- BrCa	, , , , , , , , , , , , , , , , , , , ,			
☐ AC x 4 cycles + T x 4 cycles doxorubicin/epirubicin***, cyclophosphamide, docetaxel				
☐ TGy x 4 cycles				
docetaxel, cyclophosphamide	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	☐ Biologic therapy: trastnzumab## × 18 cycles			
	Anti-emetic, specify			
	Antimicrobials, specify			
	Pain relievers, specify			
	Other medicines, specify			
"Trastuzumab for HER+BrCa; modify chemotherapy regimen as TCH simultaneously)				
Certified correct by:	Certified correct by:			
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist			
PhilHealth Accreditation No.	PhilHealth Accreditation No.			
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)			
2	Conforme by:			
	(Printed name and signature) Patient			
Date: 12/2	Date signed (mm/dd/yyyy)			
S. S. S. S. S. S. S. S. S. S. S. S. S. S				





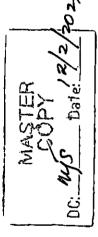
UNIVERSAL HEALTH CARE

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Case No		KALUSUDAN AT WALING
	An	nex "C1 – CABG"
HEALTHCAR	E PROVIDER (HCP)	
ADDRESS OF	HCP	
A PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX
		🗆 Male 🗆 Female
	2. PhilHealth ID Number	
B. MEMBER		" (M 2 )
	1. Last Name, First Name, Suffix, Middle Name	and the second
	2. PhilHealth ID Number	- [
	CHECKLIST OF MANDATORY and OTHER SERVICE	ES
Standard I	Piols Flootive Coronery Actom, Bynass Craft Surgary (CAR)	C) — Tranche 1

Place a ( ) in the appropriate tick box if the service is done or given.

MANDATORY SERVICES	other services as needed/as indicated
Preoperative laboratory tests such as:	
□ Platelet count	
☐ Blood typing	
□ Na · · · · · · · · · · · · · · · · · ·	
□ Mg .	
□ Calcium	
□ FBS.	
□ BUN	
☐ Creatinine	
☐ Chest X-ray (PA/lateral)	
☐ 12-lead EOG	
☐ Room air arterial blood gas	
☐ Protime-INR	
☐ Plasma thromboplastin time	
Medications	Tick appropriate box if not given
☐ Beta blocker OR calcium antagonist	☐ contraindicated ☐ will cause adverse reaction
□ Statin	contraindicated
	☐ will cause adverse reaction
☐ Ace inhibitor OR ARB	□ contraindicated □ will cause adverse reaction
☐ Aspirin OR anti-platelet	☐ contraindicated
	☐ will cause adverse reaction
☐ Preoperative antibiotic prophylaxis	☐ contraindicated ☐ will cause adverse reaction
	LI WIII CAUSE AUVEISE TEACHOIT





Revised as of November 2021

Place a (1) in the appropriate tick box if the service is done or given.

MANDATORY SERVICES	OTHER SERVICES
	as needed/ as indicated
☐ Open heart surgery under general anesthesia	
☐ Immediate postoperative care at surgical ICU	
	☐ Blood bank screening and blood products, as indicated
	☐ Continuing postoperative care
	☐ Additional laboratory tests
	☐ Postoperative antibiotics (IV and oral)
Treatments	
☐ Incentive spirometry	
	☐ VTE Prophylaxis
	☐ Nebulization with medications
	such as beta agonist + steroid or
	salbutamol/pulmonary
	physiotherapy
	☐ Blood glucose monitoring
	☐ Wound dressings/wound care
	☐ Renal replacement therapy
	☐ Other medications, specify:
	☐ Pulmonary care, as indicated, such as
	ventilator support; nebulization with a
	beta 2 agonist alone or with steroid or
	anticholinergic combinations
	☐ Other specialty services as needed, such
	as pulmonology, nephrology, neurology,
	infectious disease, etc.
Certified correct by:	Certified correct by:
(Printed name and signature)	(Printed name and signature)
Attending Cardiologist	Attending Cardiovascular Surgeon
Accreditation No.	Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

HEALTHCAR	E PROVIDER (HCP)	
ADDRESS OF	HCP	
A. PATIENT	1. Last Name, First Name, Suffin	x, Middle Name SEX ☐ Male ☐ Female
a de la companya de l	2. PhilHealth ID Number	
B. MEMBER	☐ Same as patient (Answer the following 1. Last Name, First Name, Suffix	ng only if the patient is a dependent) k, Middle Name
	2. PhilHealth ID Number	
Certified correct	And the second s	Certified correct by:
(Print	ted name and signature) Anesthesiologist	(Printed name and signature) Authorized Blood Bank Staff
PhilHealth Accreditation No.	3	PRC License No.
Date signed (m	nm/dd/yyyy)	Date signed (mm/dd/yyyy)
	Parameter and the second secon	
Conforme by:		
	ted name and signature) Patient/Guardian	







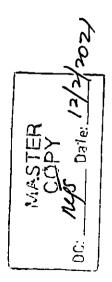


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Case No.	<del></del>	Annex "C1.1 – Cervical CA"
HEALTH CAI	RE PROVIDER (HCP)	
ADDRESS OF	HCP	
A. PATIENT	1. Last Name, First Name, Suffix	s, Middle Name    SEX   Male   Female
	2. PhilHealth ID Number	
B. MEMBER	☐ Same as patient (Answer the followin 1. Last Name, First Name, Suffix	
· .	2. PhilHealth ID Number	
Place a (✓) in t	CHECKLIST OF MANDATO Surgery for Cervical Can the appropriate tick box if the service	cer Stage IA1, IA2-IIA1  is done or given.
MAN	DATORY SERVICES	OTHER SERVICES  as needed/ as indicated
Preoperative La	iboratory:	1 1 m 2 m
	The state of the s	☐ Partial thromboplastin time
☐ Platelet		☐ CT scan or MRI
☐ Blood t		☐ Blood support (screening, processing)
	K-ray,	□ Cystoscopy
☐ EOG_		
☐ FBS	1 - 1 - 22 - 2	
□ Na, K,		
☐ Creatin		
☐ AST/A	LT	
☐ Pro-tim	e.	
☐ Urinaly	sis 👢 🗀	
🗆 Histopa	thology	
□ TV-UT	Z,×	
☐ Preoperativ	e antibiotic prophylaxis	
-		☐ Procedure done
v 1.		Date of procedure:
		(mm/dd/yyyy)
		For Stage IA1 alone:
	r Hell	Extrafascial/Total Hysterectomy with or without bilateral salpingoophorectomy
1		For stage 1A2 -1B1:
		Radical Hysterectomy with bilateral pelvic lymphadenectomy, paraortic lymph node
		sampling



MANDATORY SERVICES	OTHER SERVICES
*	as needed/ as indicated (Tick appropriate box; choose one)
	☐ bilateral salpingoophorectomy
	transposition of ovaries
	☐ Blood transfusion support
	Postoperative laboratory
The state of the s	☐ CBC with platelet
	□ ECG
	☐ Electrolytes *
	Postoperative medications
The state of the s	☐ Analgesics
	☐ Antibiotics
	☐ Hematinics ;
Certified correct by:	Certified correct by:
(Printed name and signature)	(Printed name and signature)
Gynecologic Oncologist	Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
	Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	Phili-fealth Accreditation No.
Date signed (mm/dd/yyyy)	-Date signed (mm/dd/yyyy)
	Conforme by:
The second secon	
	% <b>.</b>
	(Printed name and signature)
The state of the s	Patient







Case No.

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		Annex "	C1.2 – Cervical CA"
HEALTH CAL	RE PROVIDER (HCP)		
	, ,		
ADDRESS OF	HCP		· <del></del>
A. PATIENT	1. Last Name, First Name, Suffix	, Middle Name	SEX
	,	,	☐ Male ☐ Female
11	a plant il roll i	[ [ [ [ ] ] ] ] [ [ ] [ ] [ ] [ ] [ ] [	T T T T T T T T T T T T T T T T T T T
	2. PhilHealth ID Number		%n-
B. MEMBER	☐ Same as patient (Answer the following	g only if the patient is a dependent)	30 No.
	1. Last Name, First Name, Suffix	, Middle Name	
	المجلوبية المستخطون المستخطون المستخطون المستخطون المستخطون المستخطون المستخطون المستخطون المستخطون المستخطون ا		
· · · · · · · · · · · · · · · · · · ·	2. PhilHealth ID Number	-/	
	The state of the s		1. A. A. A. A. A. A. A. A. A. A. A. A. A.
	CHECKLIST OF MANDATO		
Chemorae	liation with Cobalt and Brachy	herapy (Low Dose) for (	Cervical Cancer
Place a (✓) in the	he appropriate tick box if the service	ic done ar given	
	الله الله الله الله الله الله الله الله	OTHER SI	ERVICES
MAN.	DATORY SERVICES	as needed/ a	/ m / 1 = 1 = 1
Preoperative La	iboratory:		
☐ CBC/		☐ Partial thrombop	astin time
☐ Platelet	<u>-</u>	□ CT scan or MRI	inomi mine
☐ Blood,t			creening, processing)
☐ Chest X		Cystoscopy."	recinity, processing/
□ EOG		Proctosigmoidos	
□ FBS		Tiocrosignioidos	ору С
□ Na, K,	Of Co	**************************************	· · · · · · · · · · · · · · · · · · ·
☐ Creatini			
□ AST/A			
☐ Pro-tim		w	
Urinaly			e de santa de la companya del companya de la companya del companya de la companya
☐ Histopa			
	Z		
To 1' ' Pri		☐ Blood transfusion Su	pport
Radiation Treat		Date of Procedure	(11/
∐ Pelvic c	obalt radiation	(start mm/dd/yyyy-end	mm/dd/yyyy):
	1 1 1	D . CD . L . /	/11/\
Low do	se brachytherapy	Dates of Procedure (mr	ıv aav yyyy):
			·



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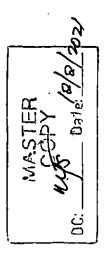
		MANDAT	ORY SE	RVIC	ES	
Chemothe	rapy medication	ns (Check only	one cher	nothera	py per cycle)	<u> </u>
	Cycle	Cisplatin	Carbo	platin	Others: (specify)	Remarks
	I	_				
	II					
	III	-				
	IV					
	VI				_	
Chemothe	rapy Treatment	Summary				<del> </del>
	Cycle	Date (mm/de	d/yyÿÿ)	10 ***	Remarks	
Į	Ī	and the second	and the same		#	
	II	Carlot Market Company	The state of the s			
	III	1 Jan 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		, T	1	5.5. A.F.
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	V	The second	7	<i>,</i>	100	
	VI	Salar Salar	· PY			\$50. <b>5</b> '
	38 8	jede <sup>r.</sup>				
			, ann	70770	<u> </u>	1.17
	it st	OTHE		ICES		
Pre chemo	therapy laborat	ory exams per	cycle			
	Cycle /	CBC	Creat	inine	Me	Urinalysis
<b> </b>	7 I pro	. je		i <sup>t</sup>	1	
<i>₩</i>	II/					
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The second	IV			, Z		
h il	<i>f</i> <b>V</b>	The second secon	- " " " " " " " " " " " " " " " " " " "			
	VI VI	<u> </u>	and a second second	النوع المادوع عدم الع	ř.	
	-10		* s	7000 7000		
Support	redications			4p:		
7	Cycle	Amu-cincucs	G-(	CSF	Hematinics	Others: specify
	I.					
)	II	•				
	III					
	IV					
	V		-			
d	VI					1

Post treatment Medications (home medications)

Cycle	Anti-emetics	Analgesics	Hematinics	Others: specify
I				
II				
III			1	
IV				
V				
VI		•		



HEALTH CAI	RE PROVIDER (HCP)	
ADDRESS OF	HCP	
A PATIENT	1. Last Name, First Name, Midd	le Name, Suffix    SEX   Male   Female
. ##"\k 	2. PhilHealth ID Number	
B. MEMBER	☐ Same as patient (Answer the following 1. Last Name, First Name, Midd	
	2. PhilHealth ID Number	
Certified correct	The second secon	Certified correct by:
	ed name and signature) necologic Oncologist	(Printed name and signature) Radiation Oncologist
PhilHealth Accreditation No.		PhilHealth Accreditation No.
Date signed (m	m/dd/yyyy)	Date signed (mm/dd/yyyy)
		# 17 # 180 # 18 19
Conforme by:	A STATE OF THE STA	Certified correct by:
(Print	ed name and signature)	(Printed name and signature)
Ì	Patient	Executive Director/Chief of Hospital/
and the same of th		Medical Director/ Medical Center Chief
Date signed (m	m/dd/yyyy)	PhilFlealth — — — — — — — — — — — — — — — — — — —
	And the second s	Date signed (mm/dd/yyyy)









Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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Case No.	
	Annex "C1.3 – Cervical CA"
HEALTHCARE PROVIDER (HCP)	
ADDRESS OF HCP	•
A. PATIENT 1. Last Name, First Name, Su	ffix, Middle Name SEX
22 2 1 1 2 2 3 3 4 4 4 4 5 5 6 5 6 6 6 6 6 6 6 6 6 6 6 6	☐ Male ☐ Female
	Company of the state of the sta
2. PhilHealth ID Number	
B. MEMBER   Same as patient (Answer the fold	
1. Last Name, First Name, Su	ffix, Middle Name
2. PhilHealth ID Number	- q
CHECKLIST OF MANDA	TORY and OTHER SERVICES
	vith Linear Accelerator
	High Dose) for Cervical Cancer
Place a (1) in the appropriate tick box if the se	rvice is done ar given
	OTHER SERVICES
MANDATORY SERVICES	
	as needed/as indicated
Preoperative Laboratory:	as needed/as indicated
Preoperative Laboratory:	as needed/ as indicated  Description:
Preoperative Laboratory:  CBC  Platelet count	as needed/as indicated  Partial thromboplastin time  CT scan or MRI
Preoperative Laboratory:  CBC  Platelet count  Blood typing	as needed/ as indicated  ☐ Partial thromboplastin time ☐ CT scan or MRI ☐ Blood support (screening, processing)
Preoperative Laboratory:  CBC  Platelet count  Blood typing  Chest X-ray	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG	as needed/ as indicated  ☐ Partial thromboplastin time ☐ CT scan or MRI ☐ Blood support (screening, processing)
Preoperative Laboratory:  CBC  Platelet count  Blood typing  Chest X-ray  ECG  FBS	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:           □ CBC           □ Platelet count           □ Blood typing           □ Chest X-ray           □ ECG           □ FBS           □ Na, K, Cl, Ca           □ Creatinine           □ AST/ALT	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ	as needed/as indicated  Partial thromboplastin time  CT scan or MRI  Blood support (screening, processing)  Cystoscopy  Proctosigmoidoscopy
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ	as needed / as indicated  ☐ Partial thromboplastin time ☐ CT scan or MRI ☐ Blood support (screening, processing) ☐ Cystoscopy ☐ Proctosigmoidoscopy ☐ Blood Transfusion Support
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ  Radiation Treatment Summary	as needed / as indicated  ☐ Partial thromboplastin time ☐ CT scan or MRI ☐ Blood support (screening, processing) ☐ Cystoscopy ☐ Proctosigmoidoscopy ☐ Blood Transfusion Support ☐ Date of Procedure
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray FBS FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ  Radiation Treatment Summary a. Pelvic radiation	as needed / as indicated  ☐ Partial thromboplastin time ☐ CT scan or MRI ☐ Blood support (screening, processing) ☐ Cystoscopy ☐ Proctosigmoidoscopy ☐ Blood Transfusion Support
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray ECG FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ  Radiation Treatment Summary	as needed / as indicated  ☐ Partial thromboplastin time ☐ CT scan or MRI ☐ Blood support (screening, processing) ☐ Cystoscopy ☐ Proctosigmoidoscopy ☐ Blood Transfusion Support ☐ Date of Procedure
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray FBS FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ  Radiation Treatment Summary a. Pelvic radiation	as needed/as indicated  □ Partial thromboplastin time □ CT scan or MRI □ Blood support (screening, processing) □ Cystoscopy □ Proctosigmoidoscopy □ Blood Transfusion Support □ Date of Procedure (start mm/dd/yyyy -end mm/dd/yyyy):
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray FBS FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ  Radiation Treatment Summary a. Pelvic radiation	as needed / as indicated  ☐ Partial thromboplastin time ☐ CT scan or MRI ☐ Blood support (screening, processing) ☐ Cystoscopy ☐ Proctosigmoidoscopy ☐ Blood Transfusion Support ☐ Date of Procedure
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray FBS FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ  Radiation Treatment Summary a. Pelvic radiation Linear Accelerator	as needed/as indicated  □ Partial thromboplastin time □ CT scan or MRI □ Blood support (screening, processing) □ Cystoscopy □ Proctosigmoidoscopy □ Blood Transfusion Support □ Date of Procedure (start mm/dd/yyyy -end mm/dd/yyyy):
Preoperative Laboratory:  CBC Platelet count Blood typing Chest X-ray FBS FBS Na, K, Cl, Ca Creatinine AST/ALT Pro-time Urinalysis Histopathology TV-UTZ  Radiation Treatment Summary a. Pelvic radiation Linear Accelerator b. Brachytherapy (tick one of the	as needed/as indicated  □ Partial thromboplastin time □ CT scan or MRI □ Blood support (screening, processing) □ Cystoscopy □ Proctosigmoidoscopy □ Blood Transfusion Support □ Date of Procedure (start mm/dd/yyyy -end mm/dd/yyyy):



# DC: MS Date: 12/2/2021

#### MANDATORY SERVICES

Chemotherapy medications (Check only one chemotherapy per cycle)

Cycle	Cisplatin	Carboplatin	Others: (specify)	Remarks
I				
II				-
III				
IV			A company of an analysis of the company of the comp	
V				
VI	,	The second secon		

Chemotherapy Treatment Summary

		# # 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Cycle	Date (mm/dd/yyyy)	Remarks
I		A Paris Company
II	A STATE OF THE STA	
III	# 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
IV.	Section 1	
V		
<b>V</b> I		
45. 45	20,00° 00.00° 000000 80	

#### OTHER SERVICES

Pre chemotherapy laboratory exams per cycle

7	Cycle	CBC	Creatinine	Mg	Urinalysis
	, l			The state of the s	
	II -	A CONTRACTOR OF THE CONTRACTOR		A <sub>a</sub> ger	
	*JII	الترسيدين.			
1	IV	A. S. William Co.		_	
3	$\mathbf{v}$				
	VI.		i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de		

Support medications

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

Post treatment Medications (home medications)

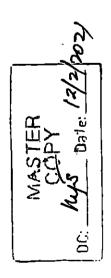
Cycle	Anti-emetics	Analgesics	Hematinics	Others: specify
I				
II				
III				
IV				
V				
VI				



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HEALTHCARE PROVIDER (HCP)				
ADDRESS OF	НСР			
A: PATIENT:	1. Last Name, First Name, Suffi	x, Middle Name	SEX	
			□ Male □ Female	
	2. PhilHealth ID Number		<b></b>	
B. MEMBER	☐ Same as patient (Answer the following 1. Last Name, First Name, Suffice 1.			
	2. PhilHealth ID Number			
Certified correc	t by:	Certified correct by:		
	ed name and signature) necologic Oncologist	(Printed name a Radiation C	nd signature) nçologist	
PhilHealth Accreditation No.		Phili leath Accreditation No.		
Date signed (m	m/dd/yyýy)	Date signed (mm/dd/yyy	у)	
Conforme by:		Certified correct by:		
(Print	ed name and signature)	(Printed name a		
	Patient	Executive Director/O Medical Director/ Me		
Date signed (m	ım/dd/yyyy)	Phill-lealth		
	1	Accreditation No. Date signed (mm/dd/yyy	<sup>2</sup> /	
		Date signed (mm) den yyy	<i>y)</i>	



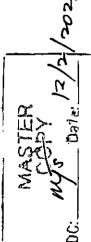




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		UNIVERSA CALUSUGAN AT	L HE
Case No		Annex "C1,1 – EMORI	)LJ:
		Annex C1.1 - EMORE	-11
HEALTH CAR	E INSTITUTION (HCI)		
ADDRESS OF	HCI		
		The state of the s	
A.PATIENT	1. Last Name, First Name, Midd	le Name, Suffix SEX ☐ Male ☐ Femal	e
	2. PhilHealth ID Number	1   1   1   1   1   1   1   1   1   1	]
B. MEMBER		ndent; otherwise, write, "same as above")	
	1. Last Name, First Name, Midd	le Name, Suffix	
	2. PhilHealth ID Number		
	DISCHARGE CHECKLIST	FOR EXPANDED ZMORPH	
	Lower Lin	nb Prosthesis	
.) 	Tra	nche 1	
		Place a check (✓) ma	ark
	CRITERIA FOR DI	Filler Her Sales S	
	wer limb prosthesis provided is a	s prescribed with appropriate ting socket, good suspension, proper	
	and stable prosthetic foot while st		
2. The lower	limb stump is free of pain, blister	, vascular compromise,	
hypersensi and/or wa	ivity after 30 minutes of prosthet	ic weight bearing while standing	
		ait parameters and steps up and down	
five (5) step	os with assistive device		
		d knowledge regarding prosthesis	
donning, d	offing, cleaning, precautions and	falling techniques	
Certified correc	t by:	Certified correct by:	
(Printe	ed name and signature)	(Printed name and signature)	
	nabilitation Medicine Śpecialist	Executive Director/Chief of Hospital/	
PhilHealth	<del></del>	Medical Director/ Medical Center Chief Philhealth	
Accreditation No.		Accreditation No.	
Date signed (mi	n/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
Case	INO.

Annex "C1.2 - EMORPH"

	Annex "Cl.2 – EMURPH
HEALTH CARE INSTITUTION (HCI)	
ADDRESS OF HCI	· · · · · · · · · · · · · · · · · · ·
A PATIENT 1. Last Name, First Name, Midd	lle Name, Suffix SEX
2. PhilHealth ID Number	
B. MEMBER (Answer only if the patient is a deposition of the p	endent; otherwise, write, "same as above") lle Name, Suffix
2. PhilHealth ID Number	
Upper Lir	TFOR EXPANDED ZMORPH  nb Prosthesis  nche 1  Place a (v) or NA if not applicable
CRITERIA FOR DI	
and fitted socket, suspension, cable systems	and terminal device
2. The upper limb stump is free of pain, bliste hypersensitivity after 30 minutes of use	r, vascular compromise,
3. Upper limb prosthesis provides at the minir	
Prosthesis user possesses competent skill ar donning, doffing, cleaning, precautions and	id knowledge regarding prosthesis
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.   -   -   Date signed (mm/dd/yyyy)	PhilHealth Accreditation No.   -   -   Date signed (mm/dd/yyyy)
	Conforme by:
	(Printed name and signature) Patient/Parent/Guardian Date signed (mm/dd/yyyy)
	Date signed (Hillin dun yyyy)
	ADDRESS OF HCI  1. Last Name, First Name, Midden 2. PhilHealth ID Number  B. MEMBER (Answer only if the patient is a deporation of the patient is a deporat



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Case No.

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		Annex "C1.3 –	EMORPH'
HEALTH CA	RE INSTITUTION (HCI)		
ADDRESS OF	HCI		
A. PATIENT	1. Last Name, First Name, Midd	le Name, Suffix	□ Female
	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the patient is a depe 1. Last Name, First Name, Midd	indent; otherwise, write, "same as above") le Name, Suffix	
	2. PhilHealth ID Number		
		FOR EXPANDED ZMORPH	
,		mb Orthosis nche 1	
		and the second of the second o	ck (✓) mark
	CRITERIA FOR DI	SCHARGE	Yes
1. External l	ower limb orthosis provided is as	prescribed with appropriate alignment	
2. The lower	limb is free of blisters, vascular coinutes of orthosis weight-bearing	ompromise, pain, hypersensitivity while standing and/or walking	
8.	b orthosis allows safe ambulation		
4. Orthosis i doffing, cl	iser possesses competent skill and eaning, precautions and falling tec	knowledge regarding donning, hniques	
Certified correc	ct by	Certified correct by:	
	ted name and signature) Phabilitation Medicine Specialist	(Printed name and signature Executive Director/Chief of Ho Medical Director/ Medical Cente	spital/
PhilHealth Accreditation No.  Date signed (m.	ım/dd/yyyy)	PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)	
		Conforme by:	:
		(Printed name and signature Patient/Parent/Guardian	e)
		Date signed (mm/dd/yyyy)	
'			



Page 1 of 1 of Annex C1.3 - EMORPH
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	Case No		Annex "C1.4 – E	EMORPH'				
	HEALTH CAI	RE INSTITUTION (HCI)						
	ADDRESS OF	FHCI	Alexander or manage manage.					
	A. PATIENT 1. Last Name, First Name, Middle Name, Suffix SEX							
		2. PhilHealth ID Number		]- [				
	B. MEMBER	(Answer only if the patient is a depe 1. Last Name, First Name, Midd	ndent; otherwise, write, "same as above") le Name, Suffix					
		2. PhilHealth ID Number		☐ - □				
	<i>/</i>	Spinal	FOR EXPANDED ZMORPH Orthosis nche 1 Place a check	x (✔) mark				
		CRITERIA FOR DI	NV CONTRACTOR OF THE CONTRACTO	Yes				
	1. Spinal ort	hosis provided is as prescribed wit	h proper alignment and appropriate					
		segment] trunk/torso is free of litivity after 30 minutes of use	olisters, vascular compromise, pain,					
	3. Spinal ort	hosis user possesses competent sk leaning, precautions and falling tec	ill and knowledge regarding donning,					
	Certified correc	ct.by	Certified correct by:					
3, N,	(Print Attending Re	ted name and signature) Phabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hos Medical Director/ Medical Center	pital/				
	PhilHealth Accreditation No.		Phill-leath Accreditation No.					
Date.	Date signed (n	nm/dd/yyyy)	Date signed (mm/dd/yyyy)					
PQ —			Conforme by:					
3			(Printed name and signature)	)				
DC: <u>/</u> ⁄			Patient/Parent/Guardian Date signed (mm/dd/yyyy)					





Universal Health Care

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Case No.					UNIVERSAL HEAL
			An	nex "C2 –	EMORPH"
HEALTH CARE INSTITUTION (HCI)	-				
ADDRESS OF LIST					
ADDRESS OF HCI	, w		The state of the s	ė.	
A. PATIENT 1. Last Name, First Name, M	1iddle Nai	ne, Suffix		SEX	
				□ Male	☐ Female
2. PhilHealth ID Number					☐ - ☐ _ ]
B. MEMBER (Answer only if the patient is a	2.5			as above")	
1. Last Name, First Name, N	Iiddle Nai	ne, Suffix			
2. Phill-lealth ID Number		]-[			
DISCHARGE CHECKL	IST FOR	EXPAN	DED Z M	ORPH	
	Tranche:				
Place a check mark (✓) on the type of prosth			a civan to	ha natiant.	
Z Benefits	leses of of	iiiosis to i		Left	Both
I. Lower limb 1. Above knee/knee	disarticul	ation -	1484	· Den	<u> </u>
prosthesis 2. Hip disarticulation					<del></del>
3. Van Ness Rotation					
II. Upper limb 4. Below elbow			31.00		
prosthesis 5. Above elbow			,		
III. Lower limb 6. Ankle foot					
orthosis 7. Knee ankle foot	2777				
8. Hip knee ankle for	1000				
IV. Spinal orthosis Thoracolumbosa	cral	□ Lumb		☐ Cervi	cothoracic
Rehabilitation Sessions		Dates I	erformed		
Physical therapy OR					
Occupational therapy					
Certified correct by:	Cert	ified corre	ect by:		
(Printed name and signature)		(Pri	nted name a	ınd signatuı	re)
Attending Rehabilitation Medicine Speciali			Director/		
			Pirector/ M	edical Cent	er Chief
Phill-fealth Accreditation No.	PhilHe Accres	atth litation No.	-		
Date signed (mm/dd/yyyy)	Date	signed (r	nm/dd/yyy	y)	
		forms b			
	Con	forme by:			
		(Pri	nted name a	ınd signatu	re)
.]		Pa	tient/Parer	ıt/Guardiar	ı
	Date		nm/dd/yy		



Page 1 of 1 of Annex C2 - EMORPH
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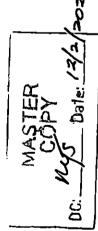


Case No		
		Annex "C1 – KT"
HEALTH CAI	RE PROVIDER (HCP)	
ADDRESS OF	FHCP	The second secon
A PATIENT	1. Last Name, First Name, Mide	dle Name, Suffix    SEX   D Male   D Female
janan da ₩ da	2. PhilHealth ID Number	1 1 2
B. MEMBER	☐ Same as patient (Answer the follow.  1. Last Name, First Name, Midd	
	2. PhilHealth ID Number	
Place a (1) in t	yr <sup>™</sup>	Kidney Transplantation (Low Risk)  iche 1  iche is done or given  OTHER SERVICES  as needed or as indicated
	clearance for recipient	☐ Cardiology clearance for donor
3 and 4) for	ant evaluation/labs (Phases 1, 2, r donor and recipient candidates ation surgery with living or onor	Hemodialysis or peritoneal dialysis during admission for transplantation
unless iden mismatch	ppressant induction therapy, tical twin or zero HLA-antigen	
crossmatch primary kid transplant,	gic risk- Negative tissue I between donor and recipient, Iney transplant, single organ PRA class 1 and 2 negative or I no donor specific antibody	





MANDATORY SERVICES	OTHER SERVICES	
Immunosuppression options:		
(Tick any one of the following)		
,		
☐ Calcineurin inhibitor + mycophenolate +		
prednisone with or without induction		
a. cyclosporine + mycophenolate mofetil		
or mycophenolate sodium +	Commence and the second country of the second secon	
prednisone OR		
b. tacrolimus + mycophenolate mofetil or		
mycophenolate sodium + prednisone		
☐ Calcineurin inhibitor + mTOR inhibitor +		
prednisone with or without induction		
a. Low-dose cyclosporine + sirolimus +		
prednisone OR		
b. Low-dose cyclosporine + everolimus		
+ prednisone		
☐ Calcineurin inhibitor such as cyclosporine		
+ azathioprine + prednisone with or		
without induction	e sincependate especialisticalists	
☐ Steroid-free for zero HLA-mismatch		
patient or induction using rabbit		
antithymocyte globulin		
Induction therapies (choose any of the following):		
☐ Interleukin-2-receptor antibody		
(basiliximab) 20 mg IV for two doses	energe en fan de fan San Gerege en de fan de fan de fan de fan de fan de fan de fan de fan de fan de fan de fa	
☐ Lymphocyte depleting agents.		
Rabbit anti-thymocyte globulin 1.0-1.5 mg		
per kg per day for three doses		
	Anti-rejection therapy	
	☐ Methylprednisolone 500 mg IV per day for	
	three days	
Certified correct by:	Conforme by:	
(Printed name and signature)	(Printed name and signature)	
Attending Nephrologist or Transplant Surgeon	Patient/Parent/Guardian	
Philf-lealth		
Accreditation No.	D / 11/-	
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)	







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

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

	Name (Last, First, MI)
	Without co-payment With co-payment
	Age Sex Male Female Civil Status: Single Married Widow Separated
	Race Hospital No
	Permanent Address
	Tel. No
	Present Address
	Tel. No.
	Attending Nephrologist Transplant Surgeon
	Name of Donor (Last, First, MI)
	Primary Renal Disease Clinical Biopsy Proven
	Duration of Dialysis Mode of Dialysis None HD PD, specify
	KT History 1st 2nd Specify,Other organ grafted
	Anemia management: B1,# units Date of last B1
	Past Medical/Social History:
	HPN DM Asthma Renal Stone COPD # of Previous
ú	CAD Stroke PVD Liver Disease Lupus Pregnancies
Q	Splenectomy Previous Surgeries Allergies
	Previous Surgeries Allergies Allergies Alcohol Intake
a	Family history HPN DM CAD Others, specify
TT N	PRE-TRANSPLANT TESTS (recent laboratory tests and indicate dates)
TER Sate	Hematology (//)
1 O.N	Blood Chemistries (//)
300	*Creatinine *BUN *FBS * Cholesterol *Trig *Uric Acid *ALP SGOT *SGPT *Albumin *Ca
- 31	*P*K*Na*Intact PTH
	Urine Examination (/) Defer if patient if anuric.
200	ll *Sp. Gr. pH Protein Sugar Blood WBC RBC
	*Urine culture and sensitivity ( / _ /_) 24-hour urine ( / / ) ECC TP
	11

<sup>\*</sup> These attachments to Annex C1-KT are for the reference of the contracted HCP which may be used for policy research. PhilHealth shall require submission of these forms; however, the PhilHealth Benefits Administration Section need not assess the clinical contents thereof during claims evaluation.



	"Stool Examination with occur blood test//	
	*Throat swab culture and sensitivity (//_)	<del></del>
	*Chest X-ray (/)	
	*Whole Abdomen US (//)	
	No. of the state o	and the state of t
	*ECG (_//_)	
	*2D Echo (/) EF%	· • • • • • • • • • • • • • • • • • • •
		1 7, 1
	Sputum c/s (/)	6.4.8.8
	Chest CT scan (//_)	1
	The state of the s	
	EGD (_ / _ / _ )	
	Colonoscopy (//	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Aorto-iliac duplex ultrasound of arteries and veins, when indicated (//_	<u>)                                    </u>
	Carotid doppler, when indicated (/_b/_/)	
	Dobutamine Stress Echo, when indicated (//)	r
	, Lucas , Luca	
	Cardiac scintigraphy (//)	
	Serology: (//)	47
1	*HBs Ag *Anti-HBc *Anti-HBs HBV-DNA *A	
$Q_{V}$	*HIV/HACI *VDRL *CMV IgG titer *EBV	*PSA (for males >50 yo)
ζη,	Immunology: "PRA Screen (//_) Class I% Class II%	, b
4	PRA Specific if PRA Screen Positive, PRA Specific/PRA Sir	ngle Antigen Bead
a	*Tissue Crossmatch (_/_/_)	
OE, iii	I south the state of the south south	, No. of HLA Mismatch
三人 で		
34. J	Immunization Status    Hepatitis B (_/_/_)    Pneumovax (_/_/_/   Clearances (Indicate the dates and physicians)	)
300 T	1 h	nittee, if LNRD
> 31	N	
	*Cardiovascular Pulmonary	
.:50	Infectious Urology/Gyn	ecology
<del></del>	DentalOthers	
	* Mandatory service	
•	Transplant Sur	ct by Attending Nephrologist or
	Traispiant Sut	Poorr
		ed name and signature
	PhilHealth Accreditation No	
	Date signed:	•
		•



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

Please answer all ques	stions comp	letely and	accurately. T	ick appropriat	e boxes.	
Name (Last, First, Midd	lle)			Any the speed and speed an	n.	
Without co-payment	2 0	<b>▲</b> *	AND THE RESERVE OF THE PARTY OF			
Age Sex	Male Fema	ale Givil S	Status: Single	Married	Widow S	Separated
Race	(p.)	A STATE OF THE STA	Hospital No.	``\ \		
Permanent Address	أوالسم متم عي	, 1919 <u>-</u>		i	* p. \$	
	الم المستملعين المبيود	The second of		Tel. No	- <u>-                                  </u>	
Present Address	A SE A	. 32.	*	1		<del></del>
	17		- 	Tel. No.		
Name and address of a c	lose relative o	or a friend v	ho can provide	information in o	ase the dono	r has a
change in address:						
	, *			,√ Te		
Nephrologist //			Transplant S		/	
Urologist	, per i	· • · -	·			
PhilHealth ID No.			-			
		3 1.2 \$ ""				
PRE-KIDNEY DONATIO	ON DATA	- NE - NE - NE - NE - NE - NE - NE - NE	ur*	gar.		
Name of Recipient (Last, Fi	rst. MD	المستسعي	السائد . السائد السائد	f		
Specific relationship to the						
Living Related I			A STATE OF THE STA			
parent	sibling	child	first cousin	nephew/niece	aunt/uncle	<b>:</b>
Living Non-rela	ted Donor	u. Dien * W		•		
State rela	tionship					
Past Medical and Social His	tory					
No Disease	HP		DM	Asthma	Renal Stone	
Previous Surgeri						
Allergies						
Smoking						
			drinks/per day x _	years		
Others, specify						
Family history HPN	DM	Domal T	Vianana amanif-			
Cirin		renal I	Disease, specify		-	

<sup>\*</sup> These attachments to Annex C1-KT are for the reference of the contracted HCP which may be used for policy research. PhilHealth shall require submission of these forms; however, the PhilHealth Benefits Administration Section need not assess the clinical contents thereof during claims evaluation.



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	Hematology (//)	
	*WBC*Hgb*Hct*Platelet*Bleeding Time*PT*PTT	
	Blood Chemistries (//)	
	*Crea BUN *FBS *Chole *Trig	
	*SGPT *K *Na Ca P *Uric Acid	
	Others	=
	Urine Examination:	
	* (//) Sp.Gr pH ProteinBloodSugarWBCRBC	
1	* (/) 24-hour urine TP or Urine Protein Creatinine ratio	
ı	* (_/_/_) Urine culture and sensitivity	
	Serology:	
1	*HBs Ag (_//_) Non-reactive Reactive	
	Anti-HBc (///) Non-reactive Reactive	
	Anti-HBs (////) Non-reactive Reactive	
1	*Anti-HCV ( / / / ) Non-reactive Reactive	
	*HIV/HACT ( // / ) Non-reactive Reactive	
ŀ		
	*VDRL/TPPA ( // _/ ) Non-reactive Reactive	
	*CMV IgG (//) Negative Positive	
	EBV IgG	
	Malarial Smear (//)/ Negative Positive	
	Other tests:	
	Stool Exam with Occult Blood: ( )	
	*Chest X-ray( // / )	
	* Whole Abdomina US ( / / )	
	*FOO( / N)	
	*EOG ( / [//])	
ΛL		
	*Ni-dead CED / ** / / / / Ni-min lined CED / - /	
1	* Nuclear GFR ( / / )ml/min Normalized GFRml/min	
1	Right ml/min %, Left ml/min %	
	Rightml/min%, Leftml/min% *CT Renal Angiography(/)	
	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / / )  * Blood Type *Tissue Typing A B , DR ,	
	Rightml/min%, Leftml/min% *CT Renal Angiography(/)	
	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / / )  * Blood Type Tissue Typing A B , DR ,  No. of HLA Mismatch	
	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / / )  * Blood Type *Tissue Typing A B , DR ,	
	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / _ )  * Blood Type *Tissue Typing A , B , DR ,  No. of HLA Mismatch  CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / _ / _ )	
	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / / )  * Blood Type *Tissue Typing A , B , DR ,  No. of HLA Mismatch  CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / / )  Pulmonary ( / _ / )	
<u></u>	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / / )  * Blood Type *Tissue Typing A , B , DR ,  No. of HLA Mismatch	
<u></u>	Right ml/min %, Left ml/min %  * CT Renal Angiography ( /	
<u></u>	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / )  * Blood Type Tissue Typing A B , DR ,  No. of HLA Mismatch CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / / )  Pulmonary ( / / )  Infectious ( / / )  Urology ( / / )  Gynecologic ( / / )	
	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / )  * Blood Type *Tissue Typing A B DR ,  No. of HLA Mismatch  CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / / )  Pulmonary ( / / )  Infectious ( / / )  Urology ( / / )  Gynecologic ( / / )  Others ( / / )	
/	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / )  * Blood Type Tissue Typing A B , DR ,  No. of HLA Mismatch CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / / )  Pulmonary ( / / )  Infectious ( / / )  Urology ( / / )  Gynecologic ( / / )	
/	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / )  * Blood Type *Tissue Typing A B DR ,  No. of HLA Mismatch  CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / / )  Pulmonary ( / / )  Infectious ( / / )  Urology ( / / )  Gynecologic ( / / )  Others ( / / )	
<u></u>	Right ml/min %, Left ml/min %  *CT Renal Angiography  *Blood Type *Tissue Typing A B DR  No. of HILA Mismatch  CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / / )  Pulmonary ( / / )  Infectious ( / / )  Gynecologic ( / / )  Others ( / / )  *Pre-transplant Orientation ( / / ) *Ethics Committee, if LNRD ( / / )	
/	Right ml/min %, Left ml/min %  * CT Renal Angiography ( / )  * Blood Type *Tissue Typing A B DR ,  No. of HLA Mismatch  CLEARANCES (Indicate the dates and physicians)  Cardiovascular ( / / )  Pulmonary ( / / )  Infectious ( / / )  Urology ( / / )  Gynecologic ( / / )  Others ( / / )	
/	Right ml/min %, Left ml/min %  *CT Renal Angiography /	ist
	Right ml/min %, Left ml/min %  * CT Renal Angiography / /	ist
/	Right ml/min %, Left ml/min %  *CT Renal Angiography /	ist
/	Right ml/min %, Left ml/min %  * CT Renal Angiography / /	ist
/	Right ml/min %, Left ml/min %  *CT Renal Angiography / /	ist
/	Right ml/min %, Left ml/min %  *CT Renal Angiography / /	ist
/	Right ml/min %, Left ml/min %  * CT Renal Angiography / /	ist
/	Right ml/min %, Left ml/min %  *CT Renal Angiography ( /	ist





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Case No. \_\_\_\_\_

Annex "C2 - KT"

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

Tranche 2				
HEALTH CARE PROVIDER (HCP)				
ADDRESS OF HCP				
A PATIENT 1. Last Name, First N	lame, Suffix, Middle Name   SEX			
2. Phill-lealth ID Nu	mber			
1. Last Name, First N	swer the following only if the patient is a dependent) Jame, Suffix, Middle Name			
2. PhilHealth ID Nu	mber			
Recipient	Dates Performed (Should be completed within two months after discharge)			
CBC (4x)				
Creatinine (4x)				
FBS (4x)				
Potassium (1x)				
SGPT (1x)	And the second s			
Lipid profile (1x)				
Therapeutic drug level (2x)				
Donor	(Should be done within one month after discharge)			
CBC (1x)				
Creatinine (1x)				
Urinalysis (1x)				
Certified correct by:	Conforme by:			
(Printed name and signature)				
Attending Nephrologist  Phill Health Accreditation No.	Patient/Parent/Guardian  Date signed (mm/dd/yyyy)			
Date signed (mm/dd/yyyy)				



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#### IMMUNOSUPPRESSIVE MEDICATIONS End Stage Renal Disease requiring Kidney Transplantation (Low Risk) Attachment to Tranche 2

			Date:
'atient's Name	Age	Sex	
Date of KT			
resent Medications			
cyclosporin	mg in the AM	mg in th	ne PM
Brand name:		25 mg tab 100 mg tab	
mycophenolate mofetil Brand name:	500 mg	tabs	times a day
mycophenolate sodium Brand name:	360 mg	tabs	times a day
tacrolimus	limg	tabs	times a day
Brand name:	0:25 mg	tabs	times a day
Brand name:	1mg	tâbs	times a day
Brand name:	mg .	tabs	times a day
Brand name:			
azathioprine Brand name:		tabs	times a day
Date:			Attending Physician
Ö			License No.
900			



<sup>\*</sup> This attachment to Annex C2-KT is for the reference of the contracted HCP which may be used for policy research. PhilHealth shall require submission of this form; however, the PhilHealth Benefits Administration Section need not assess the clinical contents thereof during claims evaluation.





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		Case No					
		Annex "C – Prostate CA"					
	ſ	HEALTH CARE PROVIDER (HCP)					
		ADDRESS OF	F HCP				
		A. PATIENT 1. Last Name, First Name, Middle Name, Suffix SEX					
			2. PhilHealth ID Number	U Male   Female			
		B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)  1. Last Name, First Name, Middle Name, Suffix				
		1	2. PhilHealth ID Number	minahahahah			
	Ľ	man vi v <u>"i</u> l	gard and the second second	DEVAND OTHER CEDEROES			
			34 LB31 1 LB31	DRY AND OTHER SERVICES  e Cancer			
		Place a (✓) in t	he appropriate tick box				
			IDATORY SERVICES	OTHER SERVICES as needed/as indicated			
`	2	Surgery do	ne (any of the following):	CP Clearance			
1	602	open radical prostatectomy.		Chest X-ray			
	/- 0	· -	roscopic radical prostatectomy	EG			
7		<del></del>	eedle biopsy or TURP specimen	Abdominal ultrasound			
~ '		☐ Prosta	te specific antigen (PSA)	☐ Bone scan			
Щ≻	Date			DCT scan/MRI of pelvis and/or abdomen			
CHC)				PET Scan			
₹010	<b>,</b>			☐ Creatinine			
< 3		ing the second		□ FBS			
			To the second of	□ CBC			
	2			☐ Electrolytes			
				☐ Urinalysis			
				☐ Medicines, specify:			
		Certified corre	ect by:	Conforme by:			
			nted name and signature) Attending Physician	(Printed name and signature) Patient/Parent/Guardian			
		PhilHealth Accreditation No.		Date signed (mm/dd/yyyy)			
		Date signed (r	nm/dd/yyyy)				
				<u> </u>			



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Page 1 of 1 of Annex C - Prostate CA

PhillHealthofficial teamphillhealth actioncenter@philhealth.gov.ph



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			Annex "C1 – TOF"
HEALTH CAR	RE PROVIDER (HCP)		
ADDRESS OF	LICD	<u> </u>	
ADDRESS OF	TICF		
A PATIENT	1. Last Name, First Name, Midd	le Name, Suffix	SEX
			☐ Male ☐ Female
	2. PhilHealth ID Number		
B. MEMBER	<ul> <li>Same as patient (Answer the following)</li> <li>Last Name, First Name, Midd</li> </ul>		
	a piller il rear i		
	2. PhilHealth ID Number		
	CHECKLIST OF MANDATO TETRALOGY OF FALLOT	manjaron Alegue interesiona mixela jeninera	
		There I faller is I to the light of the ligh	
TO	Tranc	57	
Place a ( $\checkmark$ ) in a	ppropriate tick box if DONE or (		SERVICES
) MAN	DATORÝ SERVICES	I. ::d	as indicated
Preoperative la	boratory /		
$  $ $\Box$ CBC $\mathbf{w}$	ith platelet with blood typing		
L Chest 2	ζ-ray (AP-L)		
	Cl,Ca		
□ Na, K,	CLCa ine		
☐ Na, K, ☐ Creatin ☐ Protime	CLCa ine		
□ Na, K, □ Creatin □ Protime □ Partial 1	CLCa ine		
□ Na, K, □ Creatin □ Protime □ Partial   □ Pre-operatin	Cl. Ca ine hromboplastin time ve antimicrobial prophylaxis		
□ Na, K. □ Creatin □ Protime □ Partial   □ Pre-operatin □ Procedure   Repair	Cl. Ca ine  hromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / <i>VSD</i>		
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operatin □ Procedure of Repair of with pulp	CL Ca ine thromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / USD monic stenosis		
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operatin □ Procedure of Repair of with pulp	Cl. Ca ine  chromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / <i>VSD</i> monic stenosis  VSD patch closure		
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operati □ Procedure of Repair of with pull	CL Ca ine  chromboplastin time ve antimicrobial prophylaxis lione of Tetralogy of Fallot / <i>VSD</i> monic stenosis VSD patch closure With RVOT patch or with		
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operatin □ Procedure Repair with pub	CL Ca ine  thromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / USD monic stenosis  VSD patch closure With RYOT patch or with infundibulectomy or pulmonary		
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operati □ Procedure of Repair with pulp	CL Ca ine  chromboplastin time  ve antimicrobial prophylaxis  lone  of Tetralogy of Fallot / VSD  monic stenosis  VSD patch closure  With RVOT patch or with infundibulectomy or pulmonary  valvotomy		
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operatin □ Procedure of Repair of with publication.	Cl. Ca ine  chromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / VSD monic stenosis VSD patch closure With RVOT patch or with infundibulectomy or pulmonary valvotomy medicines		
□ Na, K. □ Creatin □ Protine □ Partial t □ Pre-operatin □ Procedure of Repair of with publication.  Intra-operative Anesthetic median	CL Ca ine  thromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / VSD monic stenosis  VSD patch closure  With RYOT patch or with infundibulectomy or pulmonary valvotomy medicines licines: (any of the following)	□ dexamethasone	
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operative Repair with pull •  Intra-operative Anesthetic med	CLCa ine chromboplastin time ve antimicrobial prophylaxis done of Tetralogy of Fallot / USD monte stenosis VSD patch closure With RVOT patch or with infundibulectomy or pulmonary valvotomy medicines licines: (any of the following) oflorane	☐ calcium gluconate	
□ Na, K. □ Creatin □ Protime □ Partial i □ Pre-operatin □ Procedure of Repair of with publication.  Intra-operative Anesthetic medians seven in fent	cl. Ca ine  chromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / VSD monic stensis VSD patch closure With RVOT patch or with infundibulectomy or pulmonary valvotomy medicines licines: (any of the following) oflorane canyl	☐ calcium gluconate ☐ sodium bicarbonate	
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operative Repair with pub  Intra-operative Anesthetic med □ seve □ fent □ mid	CL Ca ine  chromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / USD monic stenosis  VSD patch closure  With RYOT patch or with infundibulectomy or pulmonary valvotomy medicines licines: (any of the following) oflorane anyl azolam	☐ calcium gluconate☐ sodium bicarbonate☐ potassium chloride	
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operative Repair with pull  Intra-operative Anesthetic med □ seve □ fent □ mid □ atro	CLCa ine chromboplastin time ve antimicrobial prophylaxis done of Tetralogy of Fallot / VSD monte stenosis VSD patch closure With RVOT patch of with infundibulectomy or pulmonary valvotomy medicines licines: (any of the following) oflorane canyl azolam opine	☐ calcium gluconate☐ sodium bicarbonate☐ potassium chloride☐ magnesium sulfate	
□ Na, K. □ Creatin □ Protime □ Partial t □ Pre-operative Repair with pull  Intra-operative Anesthetic med □ seve □ fent □ mid □ atro	CL Ca ine  chromboplastin time ve antimicrobial prophylaxis lone of Tetralogy of Fallot / USD monic stenosis  VSD patch closure  With RYOT patch or with infundibulectomy or pulmonary valvotomy medicines licines: (any of the following) oflorane anyl azolam	☐ calcium gluconate☐ sodium bicarbonate☐ potassium chloride	



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Place a (1) in the appropriate tick box if DONE	or GIVEN.			
MANDATORY SERVICES	OTHER SERVICES			
	as needed/ as indicated			
	Inotropes, as indicated: (any of the following)			
	dopamine dopamine			
	□ dobutamine			
	☐ nitroglycerine			
	pi epinephrine			
	Blood products support			
	☐ Fresh whole blood (FWB)			
	☐ Packed red blood cells (pRBC)			
	☐ Fresh frozen plasma (FFP)			
☐ Ventilatory support	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Postoperative Laboratory !				
☐ CBC with platelet				
☐ Chest x-ray (portable)				
□ PT				
□ PTPA \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\				
□ Na, K, Ca				
□ ABG				
(Pre-discharge) laboratory and diagnostics				
□ CBC				
☐ Chest X-ray (PAL)				
☐ Transthoracic echo prior to discharge				
(Attach results in the patient's chart)				
Postoperative medications				
Inotropes: (any of the following)	☐ calcium gluconate			
☐ dopamine	Pain reliever			
☐ dobutamine	☐ tramadol OR			
☐ nitroglycerine drip	☐ ketorolac OR			
☐ epinephrine	☐ other pain reliever: specify			
*	Sedative OR			
en de la companya de la companya de la companya de la companya de la companya de la companya de la companya de La companya de la  midazolam OR				
	□ propofol OR			
	□ fentanyl			
	other sedative: specify			
	☐ antimicrobials			
	☐ H2 blocker			
	☐ oral digoxin			
	☐ oral digoxiii			
	☐ oral vasodilator			
	paracetamol or ibuprofen			
North Balling Tight 1997 - A mainteight 1999 - A mainteight 1999 - A mainteight 1997 - A mainteight 1997 - A m	- Paracetamor or ibuproteir			



HEALTH CARE PROVIDER (HCP)						
ADDRESS OF HCP						
A. PATIENT	1. Last Name, First Name, Midd	le Name, Suffix  SEX  Male   Female				
	2. PhilHealth ID Number					
B. MEMBER	☐ Same as patient (Answer the followin  1. Last Name, First Name, Midd					
E.	2. PhilHealth ID Number					
			Co. Marine Co. Co. Co. Co. Co. Co. Co. Co. Co. Co.			
Certified correct	t by:	Certified correct by:				
	red name and signature)	(Printed name a				
PhilHealth Accreditation No.	ardiovascular Surgeon	Cardiovascular An PhilHealth Accreditation No.	estnesiologist			
Date signed (m	lm/dd/yyyy)	Date signed (mm/dd/yyy	<u>                                     </u>			
		.i	- 44 % - 44 M			
Certified correc	et bý	Certified correct by:	.,*			
	ed name and signature) ding Pediatric Cardiologist	(Printed name a Executive Director/ Medical Director/ Me	Chief of Hospital/			
PhilHealth Accreditation No.		Phill-lealth Accreditation No.				
Date signed (m	.m/,dd/,yyyy)	Date signed (mm/dd/yyy	y)			
Documents rec	eived his	Conforme by:				
Documents 100	4	. Comomic oy.				
	ted name and signature) Benefits Coordinator	(Printed name a Parent/G				
Date signed (m		Date signed (mm/dd/yyy				
1	<del> </del>					
<u> </u>						
1						
!						



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	Case No	<u>-</u>				
			Annex "C1 – VSD"			
	HEALTH CARE PROVIDER (HCP)					
	ADDRESS OF	T HCP	<del></del> -			
	A DATETERYT	A STREETHINGS WITH A T DY TI' DT DE'111 DT O CC'				
	A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX ☐ Male ☐ Female				
		2. PhilHealth ID Number				
	B. MEMBER	ER  Same as patient (Answer the following only if the patient is a dependent)  1. Last Name, First Name, Middle Name, Suffix				
		2. PhilHealth ID Number				
	VENTRICULAR SEPTAL DEFECT CHECKLIST OF MANDATORY and OTHER SERVICES  Tranche 1 Place a (\(\sigma\) in appropriate tick box if DONE or GIVEN:					
	MANDATORY SERVICES  OTHER SERVICES  as needed/ as indicated					
	Preoperative Medications, Laboratory and Ancillary procedure					
120	☐ CBC with p ☐ Na, K, Cl, ☐ Creatinine ☐ Protime ☐ Partial thro ☐ Chest x-ray	platelet with blood typing Ca  mboplastin time (AP-L)  ve antimicrobial prophylaxis	Please indicate if Additional laboratory and or ancillary procedure:  Description 2D ECHO CFDS if initial echo was done outside Description Others (specify):			
L	Procedure done: VSD Patch closure					
Š	Intra-operative <i>Medications, Laboratory and Ancillary procedure</i> Anesthetic medicines: (any of the following)					
	Sevoflorand Fentanyl Midazolam Atropine Ketamine Esmeron		<ul> <li>□ Dexamethasone</li> <li>□ Calcium Gluconate</li> <li>□ Sodium Bicarbonate</li> <li>□ Potassium Chloride</li> <li>□ Magnesium Sulfate</li> <li>□ Heparin</li> </ul>			
			☐ Protamine Sulfate			



Place a (✓) in the appropriate tick box if DONE or GIVEN.

Trace a (*) If the appropriate a	CR DOX II DOT CI VIII (
MANDATORY SER	VICES OTHER SERVICES as needed/ as indicated
☐ Ventilatory support	Blood products support
Inotropes: (any of the following	r)
☐ Dopamine	☐ Packed red blood cells (pRBC)
☐ Dobutamine	☐ Fresh frozen plasma (FFP)
☐ Nitroglycerine	
☐ Epinephrine	
Postoperative N	Medications, Laboratory and Ancillary procedure
Respiratory support	☐ Others (Specify)
□ Ventilator	
☐ O2 Mask / Cannula	
Laboratory and Ancillary Pro	rcedute
☐ CBC with platelet	
☐ Chest x-ray (portable)	
□ PT	
□ PTPA	
□ Na, K, Ca	
□ ABG	
☐ 2DECHO CFDS TIE /	THE CONTRACTOR OF THE CONTRACT
Medications	Medications
	그는 그 말에 살아가 되었다. 그 바다는 사람들이 가장 그를 가장 하는 것이 모든 그를 가장 하는 것이다.
Inotropes (any of the following	
☐ Dopamine	Rocuronium
☐ Dobutamine	
☐ Nitroglycerine Drip	Pain reliever
☐ Epinephrine	□ Tramadol OR
Others Specify	☐ Ketorolac OR
	□ other pain reliever: specify
Sedative	
☐ Midazolam OR	Other Medications
	☐ Calcium Gluconate
☐ Propofol OR	
☐ Fentanyl	☐ Antimicrobials
other sedative: specify:	
	☐ Oral Digoxin
1	☐ Oral Diuretic
	☐ Oral Vasodilator
. #	☐ Paracetamol Or Ibuprofen
1	☐ Others (Specify):
Pre-discharge 1	Medications, Laboratory and Ancillary procedure
☐ CBC and Platelet Count	
☐ Chest x-ray (PAL)	
• • •	diachama
Attach results in the patien	
I ATTACH TESTITS IN THE DATIEN	ES CRATEL

HEALTH CARE PROVIDER (HCP)						
ADDRESS OF	ADDRESS OF HCP					
A PATIENT	1. Last Name, First Name, Middl	e Name, Suffix	SEX  Male Female			
	2. PhilHealth ID Number		New York Control of the Control of t			
B. MEMBER	☐ Same as patient (Answer the followin 1. Last Name, First Name, Middl					
	2. PhilHealth ID Number					
Certified correct		Certified correct by:				
	ed name and signature).	(Printed name and signature)  Cardiovascular Anesthesiologist				
	ardiovascular Surgeon		estnesiologist_			
PhilHealth Accreditation No.		Phill-fealth Accreditation No.				
Date signed (m	m/dd/yyyy)	Date signed (mm/dd/yyy	·y)			
Certified correc	t by:	Certified correct by	·			
(Print	ed name and signature)	(Printed name a				
Attend	ling <i>Pediatric</i> Cardiologist	Executive Director/ ( Medical Director/ Medical				
PhilHealth Accreditation No.		PhilHealth Accreditation No.				
Date signed (m	m/dd/yyyy)	Date signed (mm/dd/yyy	ry)			
Documents rec	reived by:	Conforme by:				
	ted name and signature)	(Printed name and signature)				
	Benefits Coordinator	Parent/Guardian				
Date signed (m		Date signed (mm/dd/yyy	7y)			







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Case No		A 660	71.4C\DDT19			
HEALTH CA	HEALTH CARE INSTITUTION (HCI)  Annex "C – ZMORPH"					
	` <i>'</i>					
ADDRESS OF	ADDRESS OF HCI					
A. PATIENT	PATIENT 1. Last Name, First Name, Middle Name, Suffix SEX  Male  Female					
	2. PhilHealth ID Number		<b>□-</b>			
B. MEMBER	(Answer only if the patient is a depe	ndent; otherwise, write, "same as above")				
	1. Last Name, First Name, Midd	le Name, Suffix				
	2. PhilHealth ID Number	1				
	DISCHARGE CHECKLIST FOR ZMORPH					
FITTIN	FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE					
	Place a check mark (✓) on the appropriate lower limb prosthesis:  □ Right lower limb □ Left lower limb □ Right and left lower limbs					
. And the second		Place a chec	k (✔) mark			
	CRITERIA FOR DISCHARGE Yes					
1. External l	External below knee lower limb prosthesis provided is as prescribed with					
appropria	appropriate pressure tolerant & sensitive areas, well-fitting socket, good suspension, aligned shank and stable prosthetic foot while standing and walking.					
2. The below	2. The below knee stump is free of pain, blister, vascular compromise,					
	hypersensitivity after 30 minutes of prosthetic weight bearing while standing &/					
	or walking.  3. Prosthesis user ambulates on even and uneven surfaces within expected gait					
parameter	parameters and steps up & down five (5) steps with or without assistive device.					
	4. Prosthesis user possesses competent skill and knowledge regarding prosthesis					
<i>j</i>	donning, doffing, cleaning, precautions and falling techniques.					
Certified corre	ct by:	Certified correct by:				
	ted name and signature)	(Printed name and signature)				
Attending Re	ehabilitation Medicine Specialist	Executive Director/Chief of Hospital/				
PhilHealth		Medical Director/ Medical Center Chief PhilHealth				
Accreditation No.		Accreditation No.				
Date signed (n	ım/ 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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### PhilHealth



## 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 8441-7442. 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	☐ Orthopedic implants
			☐ Breast cancer	☐ PD First Z benefits
			☐ Prostate cancer	☐ Colorectal cancer
			☐ Kidney transplantation	☐ Prevention of preterm delivery
	1		☐ Cervical cancer	☐ Preterm and small baby
	Ū,		☐ Coronary artery bypass surgery	☐ Children with developmental disability
	Ŋ		☐ Surgery for Tetralogy of Fallot	☐ Children with mobility impairment
1	-//-	<b>1</b>	☐ Surgery for ventricular septal defect	☐ Children with visual disability
	\n		☐ ZMORPH/Expanded ZMORPH	☐ Children with hearing impairment
ľ	u)	1		
$\alpha$	ate:/	2.	Respondent's age is:	
ШŽ	37		☐ 19 years old & below	
	ا رم		☐ between 20 to 35	
<i>¥33</i>	0 1		☐ between 36 to 45	
≥'`'	31		☐ between 46 to 55	
	ZI. I		☐ between 56 to 65	
			☐ above 65 years old	
	00	_		
		3.	Sex of respondent	
			□ male	
			☐ female	
		Foi	ritems 4 to 8, please select the one best respo	onse 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 HCl 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:
(\$0£) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Thank you. Your feedback is important to us!
ASTER 20PY — Date:	Signature of Patient/ Parent/ Guardian
10: 12 N	Date accomplished:





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_		Annex "E1 – ALL"				
HEALTH CA	HEALTH CARE PROVIDER (HCP)					
ADDRESS OF	ADDRESS OF HCP					
A PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX				
	□ Male □ Female					
	2. PhilHealth ID Number					
B. MEMBER	4	lent)				
	1. Last Name, First Name, Middle Name, Suffix					
	2. PhilHealth ID Number					
DATE OF EN	DOE MANAGEMENT AND ASSESSED ASSESSED.	Herry Activity				
DATE OF EN	ND OF INDUCTION PHASE (mm   dd/ yyyy)					
CHECKL	IST OF REQUIREMENTS FOR REIMBURSEMENT	(TRANCHE 1)				
	Acute Lymphocytic/Lymphoblastic Leukemia (Standar	174.7 G				
	Induction Phase					
Requirement		Please Check				
1. Checklist o	of Requirements for Reimbursement (Tranche 1)					
\						
	-AIL)					
2. Photocopy	-ALL) of approved Pre -Authorization Checklist & Request					
2. Photocopy (Annex A-	-ALL)  of approved Pre –Authorization Checklist & Request ALL)					
2. Photocopy (Annex A-	-ALL)  of approved Pre –Authorization Checklist & Request ALL)  of completely accomplished ME FORM (Annex B)					
2. Photocopy (Annex A- 3. Photocopy 4. Properly accept	-ALL) of approved Pre -Authorization Checklist & Request ALL) of completely accomplished ME FORM (Annex B) omplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefi	t				
Photocopy     (Annex A-     Photocopy     A. Properly accepting the photocopy     Checklist of the photocopy	-ALL)  of approved Pre – Authorization Checklist & Request ALL)  of completely accomplished ME FORM (Annex B)  omplished Phill-lealth Claim Form (CF) 1 or Phill-lealth Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)	t				
2. Photocopy (Annex A- 3. Photocopy 4. Properly acco Eligibility I 5. Checklist of 6. Photocopy	ALL)  of approved Pre –Authorization Checklist & Request ALL)  of completely accomplished ME FORM (Annex B)  mplished Phill lealth Claim Form (CF) 1 or Phill Health Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  of completed Z Satisfaction Questionnaire (Annex D)	t				
2. Photocopy (Annex A- 3. Photocopy 4. Properly acco Eligibility I 5. Checklist of 6. Photocopy	-ALL)  of approved Pre – Authorization Checklist & Request ALL)  of completely accomplished ME FORM (Annex B)  omplished Phill-lealth Claim Form (CF) 1 or Phill-lealth Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)	t				
2. Photocopy (Annex A- 3. Photocopy 4. Properly according to the second	ALL)  of approved Pre –Authorization Checklist & Request ALL)  of completely accomplished ME FORM (Annex B)  mplished Phill lealth Claim Form (CF) 1 or Phill Health Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  of completed Z Satisfaction Questionnaire (Annex D)	t				
2. Photocopy (Annex A- 3. Photocopy 4. Properly according to the second	ALL)  y of approved Pre – Authorization Checklist & Request ALL)  y of completely accomplished ME FORM (Annex B)  mplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  y of completed Z Satisfaction Questionnaire (Annex D)  PLETED (mm/dd/yyyy):	t				
2. Photocopy (Annex A- 3. Photocopy 4. Properly according to the second	ALL)  y of approved Pre – Authorization Checklist & Request ALL)  y of completely accomplished ME FORM (Annex B)  mplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  y of completed Z Satisfaction Questionnaire (Annex D)  PLETED (mm/dd/yyyy):  D (mm/dd/yyyy):	t				
2. Photocopy (Annex A- 3. Photocopy 4. Properly acce Eligibility I 5. Checklist o 6. Photocopy DATE COMP	ALL)  y of approved Pre – Authorization Checklist & Request ALL)  y of completely accomplished ME FORM (Annex B)  mplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  y of completed Z Satisfaction Questionnaire (Annex D)  PLETED (mm/dd/yyyy):  D (mm/dd/yyyy):	t				
2. Photocopy (Annex A- 3. Photocopy 4. Properly according Eligibility I 5. Checklist of 6. Photocopy DATE COMP DATE FILEI  Certified correct	y of approved Pre – Authorization Checklist & Request ALL) y of completely accomplished ME FORM (Annex B) mplished Phill Health Claim Form (CF) 1 or Phill Health Benefit Form (PBEF) and CF 2 of Mandatory and Other Services (Annex C1-ALL) y of completed Z Satisfaction Questionnaire (Annex D) PLETED (mm/dd/yyyy):  O (mm/dd/yyyy):  Ct by:  Conforme by:					
2. Photocopy (Annex A- 3. Photocopy 4. Properly acce Eligibility I 5. Checklist o 6. Photocopy DATE COMP DATE FILEI  Certified correct (Print	rof approved Pre – Authorization Checklist & Request ALL)  rof completely accomplished ME FORM (Annex B)  complished Phill-lealth Claim Form (CF) 1 or Phill-lealth Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  rof completed Z Satisfaction Questionnaire (Annex D)  PLETED (mm/dd/yyyy):  O (mm/dd/yyyy):  Ct by:  Conforme by:	nd signature)				
2. Photocopy (Annex A- 3. Photocopy 4. Properly according Eligibility I 5. Checklist of 6. Photocopy DATE COMP DATE FILEI  Certified correct (Print	ALL)  y of approved Pre – Authorization Checklist. & Request ALL)  y of completely accomplished ME FORM (Annex B)  mplished Phill Tealth Claim Form (CF) 1 or Phill Health Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  y of completed Z Satisfaction Questionnaire (Annex D)  PLETED (mm/dd/yyyy):  Ct by:  Conforme by:  ted name and signature)  Attending Physician  (Printed name a Parent/G	nd signature)				
2. Photocopy (Annex A- 3. Photocopy 4. Properly acce Eligibility I 5. Checklist o 6. Photocopy DATE COMP DATE FILEI  Certified correct (Print	rof approved Pre – Authorization Checklist & Request ALL)  rof completely accomplished ME FORM (Annex B)  complished Phill-lealth Claim Form (CF) 1 or Phill-lealth Benefit Form (PBEF) and CF 2  of Mandatory and Other Services (Annex C1-ALL)  rof completed Z Satisfaction Questionnaire (Annex D)  PLETED (mm/dd/yyyy):  O (mm/dd/yyyy):  Ct by:  Conforme by:	nd signature)				



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Page 1 of 1 of Annex E1 – ALL





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Case No			Anne	ex "E2 – ALL"	
HEALTH CARE PROVIDER (HCP)					
ADDRESS OF	ADDRESS OF HCP			ર્ધ સ્થા	
A. PATIENT	1. Last Name, First Name, Midd	lle Name, Suffix	SEX	Male 🗆 Female	
	2. PhilHealth ID Number				
.B. MEMBER	☐ Same as patient (Answer the follow 1. Last Name, First Name, Midd	n graden i i i i i i i i i i i i i i i i i i i	a dependent)	10 mm m m m m m m m m m m m m m m m m m	
	2. PhilHealth ID Number			<u>.</u>	
DATE OF EN	D OF INTENSIFICATION OR	RE-INDUCTION I	PHASE (mm)	/ dd/ yyyy)	
A A	ST OF REQUIREMENTS FO Acute Lymphocytic/Lymphobla olidation, Interim Maintenance	astic Leukemia (St	andard Risl	k)	
Requirements				Please Check	
(Annex	Checklist of Requirements for Reimbursement (Tranche 2)     (Annex E2-ALL)				
	accomplished PhilHealth Claim Form ist of Mandatory and Other Service				
4. Photoc	opy of completed Z Satisfaction (				
l <u> </u>	DATE COMPLETED (mm/ dd/ yyyy):  DATE FILED (mm/ dd/ yyyy):				
Certified correct	rt by:	Conforme by:			
(Printed name and signature) (Printed			name and sig		
PhilHealth Accreditation No.  Date signed (m.	attending Physician	Pare   Date signed (mm/	ent/Guardia dd/yyyy)	<u>n</u>	
-une signed (III	<i>13331</i>				





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					Annex "E3 – ALL"	
		HEALTH CAR	RE PROVIDER (HCP)	<del></del>		
		ADDRESS OF	<sup>3</sup> HCP			
		A. PATIENT	1. Last Name, First Name, Mid	dle Name Suffix	SEX	
	·		1. Last I valle, I list I valle, Ival		☐ Male ☐ Female	
			2. PhilHealth ID Number		-	
		B. MEMBER	☐ Same as patient (Answer the follo	· = 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	ndent)	
			1. Last Name, First Name, Mid	dle Name, Suffix		
			2. PhilHealth ID Number			
		DATE OF EN	D OF 6" MAINTENANCE CY	CLE (mm/dd/yyyy)		
	'				- विशेष १ (विशेष सर्वे	
			IST OF REQUIREMENTS F			
		Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk) After 6 <sup>th</sup> Maintenance Cycle				
	1	Requirements			Please Check	
	202	(Annex	ist of Requirements for Reimbur E3-ALL)			
	1/		accomplished PhilHealth Claim Form			
	4		ist of Mandatory and Other Servi opy of completed Z Satisfaction			
#<	Daje:		PLETED (mm/dd/yyyy):	Questionnane (runiex 12)		
	\ နို		) (mm/dd/yyyy):			
0,0 €0 ∑	15	0 :: 1	1			
æ	3,	Certified correc	л ру:	Conforme by:		
	DC:_		· · · · · · · · · · · · · · · · · · ·	/D : 1		
		(Print	ted name and signature) Attending Physician		and signature) Guardian	
		PhilHealth Accreditation No.		Date signed (mm/dd/y		
		Date signed (m		1		
				<u> </u>		





Case No. \_\_\_\_\_

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			Annex "l	E1 – Breast CA"
HEALTH CA	ARE PROVIDER (HCP)			
ADDRESS C	F HCP			
A. PATIENI	1. Last Name, First Name, Mi	ddle Name, Suffix	I .	EX Male 🗆 Female
	2. PhilHealth ID Number			
B. MEMBER	☐ Same as patient (Answer the follo 1. Last Name, First Name, Mi	wing only if the patient is a deddle Name, Suffix	ependent)	The state of the s
	2. Phill-lealth ID Number			<u> </u>
CHECK	LIST OF REQUIREMENTS I	FOR REIMBURSE Early Breast Cancer		RANCHE 1)
Requirement	s // //			Please Check
	of Requirements for Reimbursem	` ,		¥
(Annex E1-Breast CA)  2. Photocopy of approved Pre – Authorization Checklist & Request (Annex A-Breast CA)				
3. Photocopy	of Completely Accomplished M			
Eligibility	omplished PhilHealth Claim Form Form (PBEF) and CF 2		ŧ	
	of Mandatory and Other Services			
	y of completed Z Satisfaction Qu faccomplished surgical operative report		)) 	
				_
8. Photocopy of accomplished anesthesia report  DATE COMPLETED (mm/dd/yyyy):				
	$\bigcap (mm/dd/yyyy):$			<del></del>
Certified corre	ct by:	Certified correct by	<i>7</i> :	
	ed name and signature)		name and si	
Phill-lealth [	Attending Surgeon	Attending PhilHealth	g Medical O	ncologist
Accreditation No.		Accreditation No.		
Date signed (n	nm/dd/yyyy)	Date signed (mm/	dd/yyyy)	
		Conforme by:		
		(Printed	name and si Patient	gnature)
		Date signed (mm/c		
i				



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Page 1 of 1 of Annex E1 - Breast CA
PhilHealthofficial teamphilhealth actioncenter@philhealth.gov.ph



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			Anne	x "E2 – Breast CA"		
	HEALTH CAI	RE PROVIDER (HCP)		<del></del>		
	4555550	T.C.				
	ADDRESS OF	' HCP				
	A PATIENT	1. Last Name, First Name, Suffi	ix, Middle Name	SEX		
				□ Male □ Female		
		2. PhilHealth ID Number		4 45.5		
	B. MEMBER	☐ Same as patient (Answer the follow 1. Last Name, First Name, Suffi		The state of the s		
	*	2. PhilHealth ID Number				
		2. Thin learn 10 Number				
	Upon comp	IST OF REQUIREMENTS For letion of one (1) month hormo and upon completion of surge	notherapy or last cycle of	chemotherapy for		
	Requirements		·	Please Check		
		f Requirements for Reimburseme	ent (Tranche 2)	21 A		
		-Breast CA) <i>mplished</i> PhilHealth Claim Form 2	The second secon	(14 전 왕) 1 전 4		
	3. Checklist of Mandatory and Other Services (Annex C2-Breast CA)					
	4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)					
	5. Photocopy of Breast Cancer Medical Records Summary Form (Annex O)					
	,		A STATE OF THE STA			
$\searrow$	Certified correct	ıt by.	Certified correct by:			
λ Q	(Print	ed name and signature)	(Printed name a	nd signature)		
74	PhilHealth	Attending Surgeon	Attending Medic	al Oncologist		
—-ch	Accreditation No.		Accreditation No.	-		
Ý	Date signed (m	m/dd/yyyy)	Date signed (mm/dd/yyyy	7)		
مخر يفأ						
PY PY Date:	1		Conforme by:			
NO121	in .		(Printed name a	nd signature)		
302	'		Patie	nt		
_ `			Date signed (mm/dd/yyyy	7)		
 				-		
ŏ	J					





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Case No. Annex "E1 - CABG" HEALTHCARE PROVIDER (HCP) ADDRESS OF HCP A. PATIENT 1. Last Name, First Name, Suffix, Middle Name SEX ☐ Male ☐ Female 2. PhilHealth ID Number B. MEMBER | D Same as patient (Answer the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name 2. PhilHealth ID Number CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1) Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG) Requirements Please Check 1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E-CABG) 2. Photocopy of approved Pre - Authorization Checklist & Request (Annex A-CABG) 3. Photocopy of completely accomplished ME\_FORM (Annex B) 4. Properly accomplished PhilHealth Claim Form (CF) 1 OR PhilHealth Benefit Eligibility Form (PBEF) and CF 2 5. Completed Checklist of Mandatory and Other Services (Annex C-CABG) 6. Photocopy of completed Z Satisfaction Questionnaire (Annex D) 7. Photocopy of accomplished surgical operative report 8. Photocopy of accomplished anesthesia report Certified correct by: Certified correct by: (Printed name and signature) (Printed name and signature) Attending Cardiologist Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief PhilHealth Accreditation No. Accreditation No. Date signed (mm/dd/yyyy) Date signed (mm/dd/yyyy) Conforme by: (Printed name and signature) Patient Date signed (mm/dd/yyyy)





Case No. \_



HEALTHCARE PROVIDER (HCP)  ADDRESS OF HCP  A PATIENT 1. Last Name, First Name, Suffix, Middle Name   SEX   Male   Famale    2. Phill-lealth ID Number   Male   Famale    3. MEMBER   Same as patient   (Answer the following only if the patient is a dependent)    1. Last Name, First Name, Suffix, Middle Name    2. Phill-lealth ID Number   -        CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)    Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)    Requirements   Please Check    1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)    2. Properly accomplished Phill-lealth Claim Form 2    3. Completed Cardiac Rehabilitation Form    4. Completed Cardiac Rehabilitation Form    4. Completed Cardiac Rehabilitation Form    4. Completed Cardiac Rehabilitation Form    5. Executive Director/ Chief of Hospital/Medical Director/ Medical Center Chief    6. Mall-Enth   Accediation No.          7. Medical Director/ Medical Center Chief    8. MEMBER   Property accomplished    8. MEMBER   Plantach   Plantach    8. MEMBER   Plantach   Plantach    9. Medical Director/ Medical Center Chief    9. Mall-Enth   Plantach    9. Medical Director/ Medical Center Chief    9. Medical Director/ Medical C			A	nnex "E	22 – CABG"
A PATIENT 1. Last Name, First Name, Suffix, Middle Name   SEX   Male   Female    2. Phill-lealth ID Number   I   Male   Female    B. MEMBER   Same as patient   Answer the following only if the patient is a dependent)  1. Last Name, First Name, Suffix, Middle Name    2. Phill-lealth ID Number   I   TRANCHE 2)  Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)  Requirements   Please Check    1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)    2. Properly accomplished Phill-lealth Claim Form 2    3. Completed Cardiac Rehabilitation Form    4. Completed Certificate of OPD Follow-up consultation    Certified correct by:   Certified correct by:    (Printed name and signature)   Executive Director/ Chief of Flospital/ Medical Director/ Medical Center Chief    Phill-lealth Accreditation No.   Accredi	HEALTHCAR	E PROVIDER (HCP)			
A PATIENT 1. Last Name, First Name, Suffix, Middle Name  2. PhilHealth ID Number  3. MEMBER  3. Ame as patient (Auswer the following only if the patient is a dependent)  1. Last Name, First Name, Suffix, Middle Name  2. PhilHealth ID Number  CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)  Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)  Requirements  1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Properly accomplished PhilHealth Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature)  Attending Cardiologist  PhilHealth Accreditation No. Date signed (mm/dd/yyyy)  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  Patient  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)  (Printed name and signature)					
B. MEMBER   Same as patient (Answer the following only if the patient is a dependant)   1. Last Name, First Name, Suffix, Middle Name   2. PhilHealth ID Number   -   -   -	ADDRESS O	3 HCP			
	A ID A CONTRACTOR	T' N O CC	3 C 1 11 3 T		
2. PhilHealth ID Number    B. MEMBER	A. PATIENT	1. Last Name, First Name, Suffin	x, Middle Name	l	. 🗆 🖘
B. MEMBER	Little III.			∐ Male	e 🗆 Female
1. Last Name, First Name, Suffix, Middle Name  2. Phill-lealth ID Number  CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2) Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)  Requirements  1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Properly accomplished Phill-lealth Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist  Phill-lealth Accreditation No.  Phill-lealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Conforme by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  Patient		2. PhilHealth ID Number	Average Stat	i Parent	
1. Last Name, First Name, Suffix, Middle Name  2. Phill Health ID Number  CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2) Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)  Requirements  Please Check  1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Property accomplished Phill Health Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature)  Attending Cardiologist  Phill Leath Accreditation No.  Phill Leath Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Conforme by:  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  Patient	B. MEMBER	☐ Same as patient (Answer the following	ng only if the patient is a dependent)	- 3	
CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2) Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)  Requirements Please Check 1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG) 2. Properly accomplished PhilHealth Claim Form 2 3. Completed Cardiac Rehabilitation Form 4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist  PhilHealth Accreditation No.  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Accreditation No.  Certified correct by:  (Printed name and signature) Accreditation No.  PhilHealth Accreditation No.  Philhealth Accreditat	\$1 x 3 f f				· ·
CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2) Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)  Requirements Please Check 1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG) 2. Properly accomplished PhilHealth Claim Form 2 3. Completed Cardiac Rehabilitation Form 4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist PhilHealth Accreditation No. Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff Patient			· · · · · · · · · · · · · · · · · · ·	<u>, , , , , , , , , , , , , , , , , , , </u>	<u>.</u>
CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2) Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG)  Requirements  Please Chect  1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Property accomplished PhilHealth Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist  PhilHealth Accreditation No.  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Accreditation No.  Certified correct by:  (Printed name and signature) Accreditation No.  PhilHealth Accre	at.	2. PhilHealth ID Number			77-
Requirements Please Chec  1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Properly accomplished PhilHealth Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist PhilHealth Accreditation No.  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) PhilHealth Accreditation No.  Certified correct by:  (Printed name and signature) PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  (Printed name and signature) Authorized Cardiac Rehabilitation Staff Patient		Learning the state of the state	*		
Requirements  Please Chec  1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Properly accomplished Phill Health Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature)  Attending Cardiologist  Phill Health Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature)  Phill Health Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature)  Phill Health Accreditation No.  Certified correct by:  (Printed name and signature)  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  Patient	CHECKL	IST OF REOUTREMENTS FO	R REÍMBURSEMENT	(TRAN	CHE 2)
Requirements   Please Check					
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Properly accomplished Phill Health Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature)  Attending Cardiologist  Phill Health Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  Certified correct by:  (Printed name and signature)  Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  Patient	-		, , , , , , , , , , , , , , , , , , ,	,	7
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-CABG)  2. Properly accomplished PhilHealth Claim Form 2  3. Completed Cardiac Rehabilitation Form  4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  Certified correct by:  (Printed name and signature) Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  (Printed name and signature) Patient	Requirements	11 / / /	7		Please Ch
2. Property accomplished PhilHealth Claim Form 2 3. Completed Cardiac Rehabilitation Form 4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature)  Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff	1. Checklist o	f Requirements for Reimburseme	nt (Tranche 2) (Annex E2-0	CABG)	
4. Completed Certificate of OPD Follow-up consultation  Certified correct by:  (Printed name and signature) Attending Cardiologist Executive Director/ Chief of Hospital/ Medical Director/ Medical Center Chief  Phill Health Accreditation No. Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Date signed (mm/dd/yyyyy)  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  Patient			3,4	7,3	
Certified correct by:  (Printed name and signature) Attending Cardiologist Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief  Phill Leath Accreditation No. Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Date signed (mm/dd/yyyy)  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  (Printed name and signature) Patient			was the same of th	ا <sup>ال</sup> ِّهِ اِلْمِ	
(Printed name and signature) Attending Cardiologist Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief  Phill Leahth Accreditation No. Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  (Printed name and signature) Phill Leahth Accreditation No. Date signed (mm/dd/yyyy)  (Printed name and signature) Patient	4. Completed	Certificate of OPD Follow-up co	nsultation		
(Printed name and signature) Attending Cardiologist Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief  Phill Leahth Accreditation No. Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  (Printed name and signature) Phill Leahth Accreditation No. Date signed (mm/dd/yyyy)  Conforme by:	11				
(Printed name and signature) Attending Cardiologist Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief  Philf-lealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature)  Conforme by:  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  Patient	<u> </u>	1	0.001		
Attending Cardiologist  Executive Director/Chief of Hospital/  Medical Director/ Medical Center Chief  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  Executive Director/Chief of Hospital/  Medical Director/ Medical Center Chief  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Conforme by:  (Printed name and signature) Patient	Certified correct	t by:	Certified correct by:		
Attending Cardiologist  Executive Director/Chief of Hospital/  Medical Director/ Medical Center Chief  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  Executive Director/ Chief of Hospital/  Medical Director/ Medical Center Chief  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Conforme by:  (Printed name and signature) Patient	(Print	ed name and signature)	Printed name	and sion	estrume)
Medical Director/ Medical Center Chief  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  Medical Director/ Medical Center Chief  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Conforme by:  (Printed name and signature) Patient					
PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Certified correct by:  Certified correct by:  Conforme by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)  Conforme by:  (Printed name and signature) PhilHealth Accreditation No.  Date signed (mm/dd/yyyy)	- Parties and the second secon		Medical Director/ N	Medical C	enter Chief
Date signed (mm/dd/yyyy)  Certified correct by:  Conforme by:  (Printed name and signature) Authorized Cardiac Rehabilitation Staff  Patient			PhilHealth		
Certified correct by:  Conforme by:  (Printed name and signature)  Authorized Cardiac Rehabilitation Staff  Conforme by:  (Printed name and signature)  Patient		-   *[		м) 	
(Printed name and signature) (Printed name and signature) Authorized Cardiac Rehabilitation Staff Patient	Date signed (iii		Date signed (min du yy)		
(Printed name and signature) (Printed name and signature) Authorized Cardiac Rehabilitation Staff Patient	- 10' 1				
Authorized Cardiac Rehabilitation Staff Patient	Centified corre	ct by:	Contorme by:		
Authorized Cardiac Rehabilitation Staff Patient	(Prin	ted name and signature)	(Printed name	and sion	ıatııre)
					muiic)
					_







Case No		Annex "E1	l.1 – C	ervical	CA"	
HEALTHCAF	RE PROVIDER (HCP)					
ADDRESS OF	НСР		-		_	
A. PATIENT 1. Last Name, First Name, Suffix Middle Name   SEX   Male   Female						
	2. PhilHealth ID Number	200 Topic of the control of the cont	~		<u> </u>	
B, MEMBER	☐ Same as patient (Answer the follown  1. Last Name, First Name, Suffi					
	2. PhilHealth ID Number				<u> </u>	
	The state of the s	er en en en en en en en en en en en en en				
CI	HECKLIST OF REQUIREME	b-	ş	ENT		
<del></del> .	Surgery for Cervical Car	ncer Stage IA1, IA2-IIA	1	1		_
Requirements				Pleas	e Che	ck_
	of Requirements for Reimburseme		CA)			
	of approved Pre - Authorization Cervical CA)	Checklist & Request				
	of completely accomplished ME	FORM (Annex R)	F.			-
4. Properly acco	omplished PhilHealth Claim Form (		fit			
	Form (PBEF) and CF 2	(A		ļ		
	of Mandatory and Other Services ( of completed Z Satisfaction Que		)			
	accomplished operative surgical report	SHOIIIAIIE (AILIEX D)		ļ		
	accomplished anesthetic report					
	y of medical certificate of the out-p	patient follow up consulta	tion	<u> </u>		-
(within 2 w	veeks post-op) with written reques	st for outpatient pap smea	ır 3			
months fro	om surgery " " " " " " " " " " " " " " " " " " "					
10. Photocopy of histopathology result (definitive surgery)						
Certified correc	et by:	Conforme by:				
/n						
(Printed name and signature) (Printed name and signature) Gynecologic Oncologist Patient						
PhilHealth Accreditation No.	irecologie Officologist	Date signed (mm/dd/y				$\dashv$
Date signed (mm/dd/xaaa)						







UNIVERSAL HEALTH CARE

Annex "E1.2 - Cervical CA"

	Γ	TIE AT TIECAD	E DROIZINED ALCON	-		
		HEALTHCARE PROVIDER (HCP)				
	-	ADDRESS OF	HCP			
		A. PATIENT	1. Last Name, First Name, Suf	fix, Middle Name	SEX  Male  Female	
			2. PhilHealth ID Number	10 mm 1 mm 1 mm 1 mm 1 mm 1 mm 1 mm 1 m		
		B. MEMBER	☐ Same as patient (Answer the follo 1. Last Name, First Name, Suf			
	Ŀ		2. PhilHealth ID Number			
			HECKLIST OF REQUIREM diation with Cobalt and Brack			
		Requirements			Please Check	
			f Requirements for Reimbursen		A) [*	
		2. Photocopy of approved Pre—Authorization Checklist & Request (Annex A-Cervical CA)				
		3. Photocopy of completely accomplished ME FORM (Annex B)				
		4. Properly accomplished Phill lealth Claim Form (CF) 1 or Phill-lealth Benefit Eligibility Form (PBEF) and CF 2				
		5. Checklist of Mandatory and Other Services (Annex C1.2-Cervical CA)				
		6. Photocopy completed Z Satisfaction Questionnaire (Annex D)				
		7. Original copy of medical certificate of Out-Patient Follow up Consultation (within 2 weeks post-procedure) with written request for out-patient pap				
		smear 3 months post-procedure				
	_			in Mari		
		Certified correc	The state of the s	Certified correct by:		
	7		ed name and signature)	(Printed name a		
	6	<del>-</del> -	necologic Oncologist	Radiation O	ncologist	
	7	PhilHealth Accreditation No.  Date signed (m	ym/dd/ynnn)	PhilHealth Accreditation No.  Date signed (mm/dd/yyy		
M _	Daje:	Pate signed (III		Date signed (mini da yyy	y) 	
PS-STE	L Da			Conforme by:		
Σ ,	\$			(Printed name a		
	ن			Date signed (mm/dd/yyy	y) 	
	0	J				





Case No. \_\_

## Republic of the Philippines



		Annex "E1.3 – Cervical CA"			
	HEALTHCARE PROVIDER (HCP)				
	ADDRESS OF LICE				
	ADDRESS OF HCP				
	A. PATIENT   1. Last Name, First Name, Suff	fix, Middle Name SEX			
		Male   Female			
	2. PhilHealth ID Number				
	B. MEMBER   Same as patient (Answer the follow	ving only if the patient is a dependent)			
	1. Last Name, First Name, Suff	fix, Middle Name			
	2. PhilHealth ID Number				
		ENTS FOR REIMBURSEMENT			
		th Linear Accelerator			
	Requirements	ligh Dose) for Cervical Cancer Please Check			
	1. Checklist of Requirements for Reimburseme				
	2. Photocopy of approved Pre - Authorization				
	(Annex A Cervical CA)				
	3. Photocopy of completely accomplished ME FORM (Annex B)				
	4. Properly accomplished PhilHealth Claim Form (	CF) 1 or PhilHealth Benefit			
	Eligibility Form (PBEF) and CF 2  5. Checklist of Mandatory and Other Services (	A			
	Photocopy completed Z Satisfaction Questionnaire (Annex D)     Original copy of medical certificate of Out-Patient Follow up Consultation				
	(within 2 weeks post-procedure) with written				
	smear 3 months post-procedure				
	Certified correct by:	Certified correct by:			
1	B Face And Control				
_\u	(Printed name and signature)	(Printed name and signature)			
<u></u>	Gynecologic Oncologist	Radiation Oncologist			
3	Phill-lealth	Phill-lealth			
	Accreditation No.	Accreditation No.			
PY Charles	Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)			
<u>a</u> a		Conforme by:			
		Comornie by:			
15/2					
02		(Printed name and cionatura)			
200		(Printed name and signature) Patient			
00: MS		(Printed name and signature) Patient Date signed (mm/dd/yyyy)			
332		(D			





## Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION



		Annex "E1	– EMORPH"		
HEALTH CARE I	NSTITUTION (HCI)	many to displace the state of t			
ADDDDOG OTTE		Section 2012 and a section of the se			
ADDRESS OF HO					
A. PATIENT 1. I	ast Name, First Name, Midd	lle Name, Suffix SEX	ig		
			Male		
	PhilHealth ID Number		-		
		endent; otherwise, write, "same as al	oove")		
1.I	ast Name, First Name, Midd	le Name, Suffix			
2 1	PhilHealth ID Number				
	i illi katti 115 I adinoci				
CHECKLIST	OF REQUIREMENTS I	FOR REIMBURSEMENT (T	RANCHE 1)		
	g2 4 1 10 10 1 10 20 2	ZMORPH	WHITE I)		
Requirements			Please Check		
1. Checklist of Rec	juirements for Reimburseme	nt (Annex E1-EMORPH)			
	2. Photocopy of approved Pre - Authorization Checklist & Request (Annex A-				
3. Photocopy of co	3. Photocopy of completely accomplished ME FORM (Annex B)				
4. Properly accomplisi	4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2				
	5. Discharge Checklist for Expanded ZMORPH (Tranche 1) (Annex C1-				
6. Photocopy of co	6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)				
Certified correct by:	<del></del>	Certified correct by:			
(Printed n	ame and signature)	(Drinted name and si			
	itation Medicine Specialist	(Printed name and si Executive Director/Chief	of Hospital/		
1777	and the second s	Medical Director/ Medical			
PhilHealth Accreditation No.		PhilHealth Accreditation No.			
Date signed (mm/d	d/yyyy)	Date signed (mm/dd/yyyy)			
		Conforme by:			
37		(Printed name and sig			
		Patient/Parent/Gu Date signed (mm/dd/yyyy)	ardian		
20		Date signed (min/ dd/ yyyy)			





# Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION



			Annex	"E2 – EMORPH"	
	HEALTH CAI	RE INSTITUTION (HCI)			
	ADDRESS OF	Ha			
	A. PATIENT	1. Last Name, First Name, Midd	lle Name, Suffix SEX	\$ *s	
		2. PhilHealth ID Number		1	
	B. MEMBER	(Answer only if the patient is a dep 1. Last Name, First Name, Mido		bove")	
		2. PhilHealth ID Number			
'	CHECK	LIST OF REQUIREMENTS	FOR REIMBURSEMENT (1	(RANCHE 2)	
ſ	Requirements	Expande	d ZMORPH	Please Check	
			EARACODUT	Flease Check	
	2. Photocopy	f Requirements for Reimburseme of approved Pre - Authorization EMORPH)	Checklist & Request.		
	3. Photocopy of completely accomplished ME FORM (Annex B)				
	4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2				
	EMORPH		and the second s		
	6. Photocopy	of completed Z Satisfaction Que	stionnaire (Annex D)		
	Certified correc	et by:	Certified correct by:		
12/2/		ed name and signature) habilitation Medicine Specialist	(Printed name and si Executive Director/Chief Medical Director/ Medica	f of Hospital/	
. (Z)	PhilHealth Accreditation No.		PhilHealth Accreditation No.		
	Date signed (m	m/dd/yyyy)	Date signed (mm/dd/yyyy)		
30/2			Conforme by:		
≥ 3			(Printed name and si Patient/Parent/Gu		
DC: _			Date signed (mm/dd/yyyy)	- LIBIT THE	
	_				





#### Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

UNIVERSAL HEALTH CARE

		- An	nex "E1 – K1"		
	HEALTH CARE PROVIDER (HCP)				
-	ADDRESS OF HCP				
		The state of the s			
	A. PATIENT 1. Last Name, First Name, Suffix				
	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Male  Female		
	2. PhilHealth ID Number				
	B. MEMBER   Same as patient / (Answer the follow				
	1. Last Name, First Name, Suffix, Middle Name				
	2. Philifiealth ID Number	<del></del>			
			(a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c		
•	CHECKLIST OF REQUIREMENTS FOR I	REIMBURSEMENT	NCHE 1)		
	End Stage Renal Disease requiring l				
		- And the second	<del>,</del>		
	Requirements,		Please Check		
	Checklist of Requirements for Reimbursement (Annex E1-KT)	nt (Tranche 1)			
	2. Photocopy of approved Pre – Authorization (	Checklist & Request			
	(Annex A-KT)	A CONTRACT OF THE CONTRACT OF			
	3. Photocopy of completely accomplished ME	FORM (Annex B)			
	4. Properly accomplished PhilHealth Claim Form (C Eligibility Form (PBEF) and CF 2	A STATE OF THE STA			
	5. Checklist of Mandatory and Other Services (	Annex C1-KT) with the			
	following attachments:  a. Pre-Transplant Evaluation Form For	Vidnos Tuncalent Posinient			
	b. Pre-Transplant Evaluation Form For				
7	6. Photocopy of completed Z Satisfaction Ques				
7	7. Photocopy of accomplished surgical operative report of				
	8. Photocopy of accomplished anesthesia report of recipie	nt and donor			
N	Certified correct by:	Canforma has			
TER PY Date: Z	Certified correct by:	Conforme by:			
	(Printed name and signature)	(Printed name and si	gnature)		
(30) P	Attending Nephrologist or Transplant Surgeon	Patient/Parent/Gu	iardian		
\$03H	PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)			
	Date signed (mm/dd/yyyy)				
اا		L			
00	J				





## Republic of the Philippines



		A	nnex "EZ – K1"
HEALTH CAI	RE PROVIDER (HCP)		
ADDRESS OF	HCP	Control of the Contro	
A. PATIENT	1. Last Name, First Name, Suffi	··	EX Male 🗅 Female
	2. PhilHealth ID Number		<u> </u>
B. MEMBER	☐ Same as patient—(Answer the follo 1. Last Name, First Name, Suffi	ving only if the patient is a dependent) x, Middle Name	r 6
	2. PhilHealth ID Number	- 1	- [
			*** * * *
	IST OF REQUIREMENTS FOR Stage Renal Disease requiring		
Requirements			Please Check
	ist of Requirements for Reimburs 2 E2-KT)	ement (Tranche 2)	
2. Properly	accomplished PhilHealth Claim For	m2	-
3. Monito followi	oring For Recipient And Donor F ng attachment: nosuppressive medications		
	opy of completed Z Satisfaction	Questionnaire (Annex D)	
Certified correc	ct by:	Conforme by:	
	ted name and signature) phrologist or Transplant Surgeon	(Printed name and s Patient/Parent/G	
PhilHealth Accreditation No.  Date signed (m		Date signed (mm/dd/yyyy)	
0C:		<u> </u>	







	Case No	Case No Annex "E - Prostate CA"						
	HEALTH CA	RE PROVIDER (HCP)						
	ADDRESS OF	F HCP		· <u> </u>				
	A PATIENT	A. PATIENT 1. Last Name, First Name, Middle Name, Suffix SEX						
		2. PhilHealth ID Number						
	B. MEMBER    Same as patient (Answer the following only if the patient is a dependent)  1. Last Name, First Name, Middle Name, Suffix							
	Mark State of the	2. PhilHealth ID Number						
	(	CHECKLIST OF REQUIREM	ENTS FOR REIMBURSEMEN	्रेटी इ.स. <b>प्राप्त</b>				
	`	44 4 TW	te Cancer					
				<sup>₹</sup>				
		Requirements	The state of the s	Please Check				
		Requirements for Reimbursemer		_				
	(Annex Ā-Í	of Approved Pre –Authorization Prostate CA)						
		of Accomplished ME FORM (A						
	Eligibility F	implished PhilHealth Claim Form 1 form (PBEF) and CF2		,				
	5. Checklist of CA)	Mandatory and Other Services fo	or Prostate CA (Annex C-Prostate					
		completed Z Satisfaction Question						
		of accomplished surgical operative	e report					
	8. Photocopy of	accomplished anesthesia report						
1	_			t				
12/2	Certified correc	ct by:	Conforme by:					
_ ::	/Dein	nted name and signature)	(Printed name and signa					
SPY Date/Z/	(F1III	Attending Physician	Patient/Parent/Gua	rdian				
2/2	PhilHealth Accreditation No.		Date signed (mm/dd/yyyy)	]				
" Sa	Date signed (m	nm/ ad/ yyyy) 						
.; DC:				1				

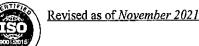






Case No					
Annex "E1 ~ TOF"					
HEALTH CARE PROVIDER (HCP)					
ADDRESS OF	F НСР	•-			
A. PATIENT	1. Last Name, First Name, Mide	lle Name, Suffix SEX			
''		☐ Male ☐ Female			
, , ,	2. PhilHealth ID Number				
B. MEMBER	☐ Same as patient (Answer the follow				
	1. Last Name, First Name, Mido	lle Name, Suffix			
~ .					
Par.	2. PhilHealth ID Number				
CLITICITY I					
CHECKL		OR REIMBURSEMENT (TRANCHE 1)			
	Tetralogy of Pallot-	Elective TOF Repair Place a check mark (  )			
Requirements		YES			
_	f Requirements for Reimburseme				
	Photocopy of approved Pre – Authorization Checklist & Request (Annex A-TOF)     Photocopy of completed ME FORM (Annex B)				
		CF) 1 or PhilHealth Benefit Eligibility			
	Ef) and CF 2				
	of completed and signed Z Satisf				
	accomplished surgical operative i	eport			
8. Photocopy of	accomplished anesthesia report				
Certified correct	ct by:	Certified correct by:			
(Print	ed name and signature)	(Printed name and signature)			
Atten	ding Pediatric Cardiologist	Executive Director/Chief of Hospital/			
Phill Health		Medical Director/ Medical Center Chief			
Accreditation No.		Accreditation No.			
Date signed (m	nm/dd/yyyy)	Date signed (mm/dd/yyyy)			
Documents rec	eived by:	Conforme by:			
(Printed name and signature) (Printed name and signature)					
Z Benefits Coordinator Parent/Guardian					
Date signed (m		Date signed (mm/dd/yyyy)			
	_ = == == ( == 7)///				







#### Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION



		Annex "E2 – TOF"			
HEALTH CA	HEALTH CARE PROVIDER (HCP)				
ADDRESS OF	HCP				
A. PATIENT	1. Last Name, First Name, Mide	dle Name, Suffix    SEX			
	2. PhilHealth ID Number	- 1			
B. MEMBER	☐ Same as patient (Answer the follow 1. Last Name, First Name, Mide				
	2. PhilHealth ID Number				
CHECKL	CHECKLIST OR REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)  Tetralogy of Fallot – Elective TOF Repair  Place a check mark ()				
Requirements		YES			
1. Checklist o	f Requirements for Reimburseme	ent (Annex E2-TOF)			
	mplished PhilHealth Claim Form 2	3 41			
	Cardiac Rehabilitation Form rtificate of OPD consultation	A STATE OF THE STA			
4. Wedicai ce	nuicate of OFD consultation				
Certified corre	et by:	Certified correct by:			
	ed name and signature) ding <i>Pediatric Cardiologist</i>	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief			
PhilHealth Accreditation No.	-	PhilHealth Accreditation No.			
Date signed (n	nm/dd/yyyy)	Date signed (mm/dd/yyyy)			
Documents rec	ceived by:	Conforme by:			
	ed name and signature) Benefits Coordinator	(Printed name and signature) Parent/Guardian			
Date signed (m		Date signed (mm/dd/yyyy)			
<u> </u>					





#### Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION



Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

	Case No				
				Annex "E1 – V	/SD"
	HEALTH CARE PROVIDER (HCP)				
	ADDRESS OF	HCP			
	A PATIENT	1. Last Name, First Name, Midd	lle Name, Suffix	SEX □ Male □ F	emale
		2. PhilHealth ID Number			- 🔲
	B. MEMBER	☐ Same as patient (Answer the follows  1. Last Name, First Name, Midd			
		2. PhilHealth ID Number			- 🔲
	CHECKL	IST OF REQUIREMENTS FO Ventricular Septal Defec	OR REIMBURSEMENT t – Elective VSD Closute		•
	Requirements	S John Jan Jan St.	2 <sup>4</sup>	1.2	YES
	1. Checklist o	of Requirements for Reimburseme	ent (Annex E1-VSD)	, `	
	2. Photocopy	of approved Pre - Authorization	Checklist & Request (Anne	ex A-VSD)	
	3. Photocopy	of completed ME FORM (Anne	ex B)	i st	
	4. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit				
	Eligibility Form (PBEF) and CF 2  5. Signed Checklist of Mandatory and Other Services (Annex C1-VSD)				
		of completed and signed Z Satist		ex D)	
		faccomplished surgical operative r			
		accomplished anesthesia report	epon:	<del></del>	
	i. Annotopy of	General Control of the Control of th			
	Certified correc	ct by:	Certified correct by:	-	
_	(Print	ted name and signature)	(Printed name a		•
-	Atten	ding Pediatric Cardiologist	Executive Director/		
		· · · · · · · · · · · · · · · · · · ·	Medical Director/ Me	edical Center Ch	uief
	Philf-fealth Accreditation No.	-               -	PhilHealth Accreditation No.	-	-
	Date signed (m	ım/dd/yyyy)	Date signed (mm/dd/yyy	y)	
	Documents rec		Conforme by:		
1		ted name and signature)	(Printed name a		
		Benefits Coordinator	Parent/G		
'	Date signed (m	nm/ dd/ vvvv)	Date signed (mm/dd/vvv	V)	



Page 1 of 1 of Annex E1 - VSD



## Republic of the Philippines



		Annex "E2 – VSD
HEALTH CA	RE PROVIDER (HCP)	
ADDRESS OF	FHCP	
A. PATIENT	1. Last Name, First Name, Mido	lle Name, Suffix SEX
W. LWITCINI	1. Last Name, Pirst Name, Midd	□ Male □ Female
*		
	2. PhilHealth ID Number	
B. MEMBER	☐ Same as patient (Answer the follows	
	1. Last Name, First Name, Mido	lle Name, Suffix
		and the second s
	2. PhilHealth ID Number	
	. जुले के किया	
CHECKL		OR REIMBURSEMENT (TRANCHE 2)
	Ventricular Septal Defec	t – Elective VSD Closure
	A STATE OF THE STA	<b>D</b>
D	A STATE OF THE STA	Place a check mark (
Requirements  1. Checklist of	of Requirements for Reimburseme	
	omplished PhilHealth Claim Form 2	22 P 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Cardiac Rehabilitation Form	y company
	rtificate of OPD consultation	
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	ding Pediatric Cardiologist	Executive Director/Chief of Hospital/
	1	Medical Director/ Medical Center Chief
PhilHealth Accreditation No.		PhilHealth Accreditation No.
Date signed (n	m/dd/1999)	Date signed (mm/dd/yyyy)
Date signed (ii)		Take Signed (Init) day yyyy)
Documents rec	reived by	Conforme by:
Documents ic		Comonina by.
		(Printed name and signature)
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(Prin	ted name and signature)	
(Print Z ) Date signed (m	Benefits Coordinator	Parent/Guardian Date signed (mm/dd/yyyy)







#### Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center (02) 8441-7442 Trunkline (02) 8441-7444 www.philhealth.gov.ph



Annex "H"

#### TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

NAME OF CONTRACTED HEALTH CARE PROVIDER (HCP)	ADDRESS OF HCP

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.

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

Case Number	Name of Patient	Period of C	onfinement	Z Benefit Package	Remarks
	(Last, First, Middle Initial, Extension)	Date admitted	Date discharged	Code	<u> </u>
1.	, i - i		rk		
2.	g 1 <sup>1</sup>		<del></del>	d	
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4.	, T <sub>i</sub> 1			٠, ' فو	
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8.			en i en i en i		
9.	1 4 0 1 B				
10.		T	*		

		4 1 to the total terms of the t	
Certified correct by authorized representative of the HCP			For PhilHealth Use Only Initials . Date
	-	Designation	Received by Local Health Insurance Office (LHIO)
	Printed Name and Signature	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)
	_	n 14	



Page 1 of 1 of Annex H PhilHealthofficial teamphilhealth actioncenter philhealth.gov.ph

## Policy Review Guide for the Z Benefits

Health Finance Policy Sector Product Team for Special Benefits

#### I. Introduction

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

#### II. Methodology

#### A. Knowledge update

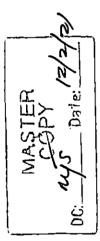
The knowledge update is the summary and synthesis of the significant and locally applicable updates in current standards of practice and medical evidence that has taken place since the initial implementation of the Z Benefits policy or since the last policy review. Trained technical staff of the Product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

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



#### B. Matrix guide for the policy review process

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



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

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

#### D. Building consensus with key stakeholders

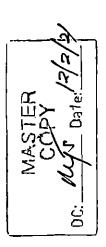
The policy review team, in collaboration with the key stakeholders, shall address the policy gaps identified and shall also consider the action plans listed in the matrix guide of the review process. Consensus building shall be conducted in order to arrive at an agreement and resolution for issues raised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

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

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

#### F. Disseminating the amendments and revisions in the policy

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



# Z BENEFIT FOR ACUTE LYMPHOCYTIC/LYMPHOBLASTIC LEUKEMIA, STANDARD RISK

IV IVI	andatory Services (Minimum Standards) Induction Phase	Other Services Induction Phase
Δ	Diagnostics	A. Other diagnostics, as indicated
R	<ol> <li>bone marrow aspirate examination (morphologic assessment of BMA smears)</li> <li>CSF analysis with WBC differential count</li> <li>CBC (with platelet count)</li> <li>alanine aminotransferase (ALT)</li> <li>bilirubin</li> <li>creatinine</li> <li>PT, PTT</li> <li>uric acid</li> <li>chest x-ray</li> <li>Electrolytes</li> </ol>	<ol> <li>calcium</li> <li>chloride</li> <li>magnesium</li> <li>phosphorous/ phosphate</li> <li>2D echocardiography</li> <li>flow cytometric immunophenotyping</li> <li>CSF cytospin</li> <li>abdominal ultrasound</li> <li>evaluation of infection (ex. blood culture, etc.)</li> <li>cytogenetics</li> </ol>
р.	1. Sodium 2. Potassium	<ul> <li>B. Blood support and processing</li> <li>1. blood typing</li> <li>2. cross-matching</li> <li>3. blood screening</li> <li>4. blood products (i.e. packed RBC, platelet concentrate, fresh frozen plasma)</li> </ul>
C.	Chemotherapy	C. Other Systemic Chemotherapy, as indicated, such as doxorubicin
_	<ul> <li>1. Systemic</li> <li>a) prednisone or dexamethasone</li> <li>b) vincristine</li> <li>c) L-asparaginase</li> </ul>	D. Other drugs, as indicated, such as diphenhydramine or hydrocortisone
13/2	2. Intrathecal a) single (methotrexate), OR	E. Antiemetics, as indicated, such as ondansetron or metoclopramide
Date: 🔼	b) triple (methotrexate, cytarabine, hydrocortisone)	F. Pain medications, as indicated, such as nalbuphine, tramadol
0C: 146 Date: 12		G. Anesthetics, as indicated, such as ketamine, propofol
) :00:		H. Sedatives prior to lab procedure, as indicated, such as midazolam, diphenhydramine
		I. Antimicrobials

1. cotrimoxazole

Mandatory Services (Minimum Standards)	Other Services Induction Phase
	2. ceftriaxone
	3. ceftazidime
	4. amikacin
	5. antifungal (oral) specify
	J. Other antimicrobials based on hospital antibiogram

Mandatory Services (Minimum Standards) Consolidation, Interim Maintenance and	Other Services  Consolidation, Interim Maintenance and
Delayed Intensification Phases	Delayed Intensification Phases
A. Diagnostics	A. Other Diagnostics, if needed
1. CSF Analysis WBC differential count	1. bone marrow aspirate examination
2. CBC (with platelet count)	2. alanine aminotransferase (ALT)
3. creatinine	3. PT/PTT
4. bilirubin	
B. Chemotherapy	B. Chemotherapy
	1. doxorubicin
1. Systemic	2. L-asparaginase
a) prednisone or dexamethasone	
b) vincristine	C. Other drugs, as indicated
c) cytarabine	1. MESNA
d) cyclophosphamide	2. hydrocortisone
e) methotrexate (IV and oral)	
f) 6-mercaptopurine	D. Antiemetics, as indicated
1	1. ondansetron
2. Intrathecal	2. metoclopramide
a) single (methotrexate), OR	
b) triple (methotrexate, cytarabine,	E. Antimicrobials
hydrocortisone)	1. co-trimoxazole
	2. ceftriaxone
1	3. ceftazidime
	4 amikacin



- 4. amikacin
- 5. antifungal (oral), specify
- 6. Other antimicrobials based on hospital antibiogram
- F. Blood products

Table 3. Services included for Maintenance Phase

#### Other Services Mandatory Services (Minimum Standards) Maintenance Phase Maintenance Phase A. Diagnostics A. Other diagnostics 1. CSF Analysis WBC differential count 1. chest X-ray 2. CBC (with platelet count) 2. bone marrow aspirate examination alanine aminotransferase (ALT) 4. creatinine 5. bilirubin 6. amylase 7. cranial CT scan 8. CSF cytospin 9. flow cytometry (to determine minimal residual disease) B. Chemotherapy B. Chemotherapy Systemic (i.e. doxorubicin) 1. Systemic C. Antiemetics, as indicated a) prednisone or dexamethasone b) vincristine 1. ondansetron c) methotrexate (oral) 2. metoclopramide d) 6-mercaptopurine D. Antimicrobials 1. co-trimoxazole 2. Intrathecal 2. ceftriaxone a) single (methotrexate), OR 3. ceftazidime b) triple (methotrexate, cytarabine, 4. amikacin hydrocortisone) 5. antifungal (oral), specify 6. other antibiotics based on hospital antibiogram: E. Blood products



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

### Z BENEFIT FOR BREAST CANCER, STAGE 0 TO IIIA

Table 1. Services included for Breast CA, Tranche 1			
Mandatory Services (Minimum Standards)	Other Services		
A. Surgery (any one of the following)  1. modified radical mastectomy  2. total mastectomy with sentinel lymph node biopsy  3. partial mastectomy of the breast/lumpectomy with axillary lymph node dissection  4. partial mastectomy/lumpectomy of the breast with sentinel lymph node biopsy	A. CP clearance		
<ul> <li>B. Diagnostics <ol> <li>mammography for all female 40 years old and above</li> <li>ultrasound of breast and axillary bed for female less than 40 years old</li> <li>ultrasound of both breasts and axillary bed for male</li> </ol> </li> <li>C. histopathology <ol> <li>ER/HER*</li> </ol> </li> </ul>	B. Diagnostics (if needed)  1. CBC (with platelet count)*  2. chest x-ray PA and later.  3. alkaline phosphatase*  4. ultrasound of whole abdomen*  5. ECG  6. creatinine  7. FBS  8. PT/PTT  9. electrolytes*  a. sodium b. potassium c. calcium d. chloride e. phosphate  10. urinalysis*  11. 2D echo **  12. SPGT*  13. SGOT*  C. other medicines		

<sup>\*</sup>Not required for cStage 0 (DCIS)

\*\* Not required for HER negative breast cancer

Table 2. Services included for Breast Cancer, Tranche 2

		Services included for Breast Cancer, Tra	ncne	
171	andat	ory Services (Minimum Standards)		Other Services
	Adju  1. Ca	doxorubicin / epirubicin*** for patients with cardiac dysfunctions, cyclophosphamide OR  OMF*** x 6 cycles cyclophosphamide, methotrexate, fluorouracil		Other drugs, as needed,  1. biologic therapy, trastuzumab ** x 18 cycles  2. anti-emetics  3. antimicrobials  4. pain-relievers  5. other medicines
		Hormonotherapy with: Tamoxifen# * 5 years	В.	Other hormonotherapy Letrozole x 5 years
_]			C.	Radiotherapy Not included in the Z Benefits but as a separate benefit under Case Rates

<sup>\*</sup>not required for Stage 0 DCIS

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

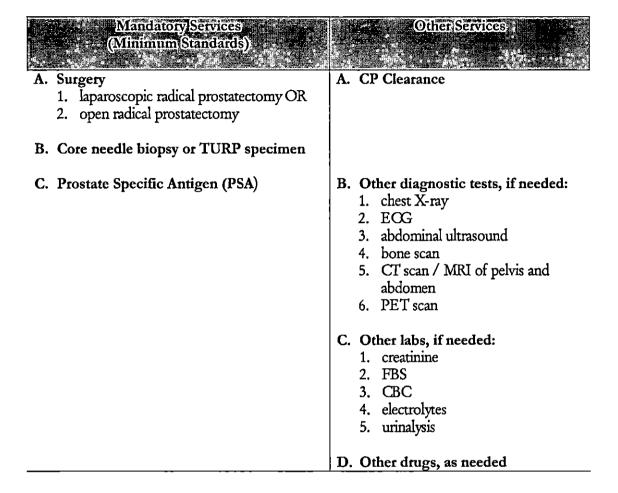
<sup>\*\*</sup> In order to achieve the expected pathological response of neoadjuvant therapy, the full 4 to 8 cycles of chemotherapy and anti-HER2 neu treatment if HER2+, depending on the protocol used, is given prior to surgery provided there is clinical response.

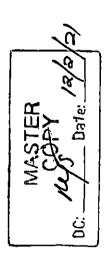
<sup>\*\*\*</sup>for elderly or those with heart disease who cannot tolerate doxorubicin; epirubicin can be given instead of doxorubicin in patients with history of heart disease

<sup>\*</sup>Tamoxifen is given for ER+ BrCa after cytotoxic chemotherapy and can be given together with trastuzumab in pre- and post-menopausal patients. Letrozole cannot be given to premenopausal patients

<sup>\*\*</sup>Trastuzumab for HER+ BrCa; modify chemotherapy regimen as TCH-H, AC+TH-H (doxorubicin and trastuzumab (H) cannot be given simultaneously)

#### Z BENEFIT FOR PROSTATE CANCER, LOW TO INTERMEDIATE RISK





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

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

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

Mandatory Services (Minimum Standards)	Other Services
A. Cardiology clearance for recipient	A. Cardiology clearance for donor, if indicated
B. Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates	<ul> <li>Hemodialysis or peritoneal dialysis during admission for transplantation, if indicated</li> </ul>
C. Transplantation surgery with living or deceased donor	C. Graft renal biopsy, if indicated
D. Immunosuppressant induction therapy, unless identical twin or zero HLA-antigen mismatch	D. Anti-rejection therapy, if indicated, with methylprednisolone 500 mg IV per day for three (3) days
E. Immunologic risk- negative tissue crossmatch between donor and recipient, primary kidney transplant, single organ transplant, PRA class 1 and 2 negative or PRA <20%; no donor specific antibody	

Table 2. Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for recipient candidate Mandatory Services Other Services (Minimum Standards) Phase 1 Phase 1 HBV-DNA if only anti-HBc+ CBC blood typing Chest CT scan PT/PTT bleeding Time **FBS** creatinine urinalysis HBsAg, anti-HBs, anti-HBc CMV IgG anti-HCV HIV **TPPA** chest x-ray ultrasound of the whole abdomen Phase 2 PRA screen PRA specific Phase 3 tissue cross-match with living donor HLA tissue typing

Mandatory Services (Minimum Standards)	Other Services
Phase 4	Phase 4
urine C/S	pregnancy test for female <45 years
sodium	old
calcium	mammogram for female >40 years
potassium	old
phosphorus	pap smear for women
lipid profile	prostate specific antigen for males
liver function tests	when indicated:
uric acid	dobutamine stress echo
fecalysis with occult blood	carotid duplex ultrasonography
EBV-IgG	aorto-iliac duplex ultrasound of
ECG	arteries and veins
2D echo	
Throat swab C/S	
dental evaluation	

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

Mandatory Services (Minimum Standards)

Other Services

	wianuatory services (winning standards)	15.4	0.	HCI SCI	VICES		- 1
	<u> </u>				1 11 1	2.15 2.25	
7	Phase 1	Phase 1					
	CBC	2]	D echo				
19	blood typing						
à	PT/PTT	]					
	bleeding Time						
一	FBS						
	creatinine						
(Sec)	urinalysis						
4 () La	HBsAg						
1 5 5	anti-HCV						
1	HIV						
	VDRL						
ا ا	chest x-ray	ĺ					
	ultrasound of whole abdomen						
	ECG						
	Phase 2						
	HLA tissue typing Phase 3						
	CMV IgG urine C/S						
	sodium						
	calcium						
	potassium						
	phosphorous						
	lipid profile						
	liver function tests						
	uric acid						
	fecalysis with occult blood						
	nuclear GFR						
	renal CT angiogram	<u> </u>				_	

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

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

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

Mandatory Services (Minimum Standards)		Other 8	Services	
Option 1: interleukin-2-receptor antibody (basiliximab) 20 mg IV for two (2) doses OR				
Option 2: lymphocyte depleting agents rabbit anti-thymocyte globulin 1.0-1.5 mg per k per day for three (3) doses	g			

Table 6. Laboratory Monitoring for Recipient and Donor

Mandatory Services (Minimum Standards)

CBC (4x)

creatinine (4x)

FBS (4x)

potassium (1x)

SGPT (1x)

lipid profile (1x)

therapeutic drug level (2x)

Donor

CBC (1x)

creatinine (1x)

urinalysis (1x)

#### Z BENEFIT FOR CORONARY ARTERY BYPASS GRAFT SURGERY

#### Table 1. Services included for coronary artery bypass graft surgery Mandatory Services (Minimum Standards) Other Services A. Blood bank screening and blood A. Preoperative laboratory tests: 1. CBC products, as indicated 2. platelet count B. Continuing postoperative care 3. blood typing C. Additional laboratory tests, if needed 4. sodium D. Postoperative antibiotics (IV and oral) 5. potassium E. Treatments, as indicated: 6. magnesium a. VTE Prophylaxis 7. calcium b. Nebulization with medications 8. FBS such as beta agonist + steroid or 9. BUN salbutamol/pulmonary 10. creatinine physiotherapy c. Blood glucose monitoring 11. chest x-ray (PA/lateral) d. Wound dressings/wound care 12. 12-lead ECG 13. room air arterial blood gas e. Renal replacement therapy 14. protime-INR 15. plasma thromboplastin time B. Medications F. Other medications, as indicated a. beta blocker OR calcium antagonist G. Pulmonary care, as indicated, such as ventilator support; nebulization, with a c. ACE inhibitor OR ARB · beta 2 agonist alone or with steroid or d. aspirin OR anti-platelet anticholinergic combinations e. preoperative antibiotic prophylaxis H. Other specialty services if needed, such

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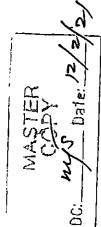
- C. Open heart surgery under general anesthesia
- D.Immediate postoperative care at surgical ICU
- E. Treatments
  - 1. Incentive Spirometry
- F. Rehabilitation sessions

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

as pulmonology, nephrology, neurology, infectious diseases, etc.

### Z BENEFIT FOR TETRALOGY OF FALLOT

Table 1. Services included for Tetralogy of Fallot					
Mandatory Services (Minimum Standards)	Other Services				
A. Preoperative laboratory:	A. Other intra-operative medicines				
1. CBC with platelet	1. dexamethasone				
2. blood typing	2. calcium gluconate				
3. chest x-ray (AP-L)	3. sodium bicarbonate				
4. Na, K, Cl, Ca	4. potassium chloride				
5. creatinine	5. magnesium sulfate				
6. protime	6. heparin				
7. partial thromboplastin time	7. protamine sulfate				
B. Pre-operative antimicrobial prophylaxis	B. Any of the following inotropes:				
C. Procedure done	1. dopamine				
repair of Tetralogy of Fallot/ VSD with	2. dobutamine				
pulmonic stenosis	2				
1. VSD patch closure	3. nitroglycerine				
2. with RVOT patch or with	4. epinephrine				
infundibulectomy or pulmonary					
valvotomy					
D. Intra-operative medicines	C. Blood product support				
Any of the following anesthetic medicines:  1. sevoflorane	C. Blood product support  1. fresh whole blood (FWB)				
	2. packed red blood cells				
2. fentanyl 3. midazolam	3. fresh frozen plasma (FFP)				
4. atropine	D. Other post-op medication				
5. ketamine	calcium gluconate				
6. esmeron	E. Other medicines, as indicated				
E. Ventilatory support	1. Pain reliever				
F. Postoperative laboratory tests:	a) tramadol OR				
1. CBC with platelet	b) ketorolac OR				
2. chest x-ray (portable)	c) other pain reliever				
3. PT	2. Sedative				
4. PTPA	a) midazolam OR				
5. Na, K, Ca	b) propofol OR				
6. ABG	c) fentanyl				
G. (Pre-discharge) laboratory and	d) other sedative				
diagnostics					
1. CBC	3. antimicrobial (based on hospital				
2. chest x-ray (PAL)	antibiogram				
3. transthoracic echo prior to discharge	4. H2 blocker				
H Postoperative medications	5. oral digoxin				
Any of the following inotropes:	6. oral diuretic				
1. dopamine	7. oral vasodilator				
2. dobutamine	8. paracetamol or ibuprofen				
3. nitroglycerine drip					
4. epinephrine					

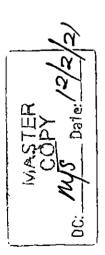


### Z BENEFIT FOR VENTRICULAR SEPTAL DEFECT

_Ta	ble 1. Services included for Surgery of Ventric	cular Septal Defect
M	andatory Services (Minimum Standards)	Other Services
	Pre-operative medication, laboratory and ancillary procedure  1. CBC with platelet with blood typing  2. Na, K, Cl, Ca  3. creatinine  4. protime  5. partial thromboplastin time  6. chest x-ray (AP-L)  7. Pre-operative antimicrobial prophylaxis  Procedure done:	A. Pre-operative medication, laboratory and ancillary procedure 2D echo CFDS
C.	VSD patch closure Intra-operative medication, laboratory and ancillary procedure  1. Any of the following anesthetic medicines: a) sevoflorane b) fentanyl c) midazolam d) atropine e) ketamine f) esmeron  2. Ventilatory support 3. Any of the following inotropes, as indicated: a) dopamine b) dobutamine c) nitroglycerine d) epinephrine	B. Other intra-operative medications, laboratory and ancillary procedures  a) dexamethasone b) calcium gluconate c) sodium bicarbonate d) potassium chloride e) magnesium sulfate f) heparin g) protamine sulfate  C. Blood products support (if applicable), such as: 1. FWB 2. pRBC 3. FFP
D.	Postoperative medication, laboratory and ancillary procedure  1. Respiratory support  a) Ventilator  a) O2 mask/cannula  2. Laboratory and ancillary procedure  a) CBC with platelet  b) chest x-ray (portable)  c) PT  d) PTPA	D. Other medications, as indicated  1. Paralysis rocuronium  2. Pain reliever a) tramadol OR b) ketorolac OR c) other pain reliever  3. calcium gluconate 4. antimicrobials
	e) Na, K, Ca f) ABG g) 2D ECHO-CFDS TTE/TEE 3. Medications a) Any of the following inotropes: 1) dopamine	<ul> <li>4. antificrobials</li> <li>5. H2 blocker</li> <li>6. oral digoxin</li> <li>7. oral diuretic</li> <li>8. oral vasodilator</li> <li>9. paracetamol or ibuprofen</li> </ul>

Annex "J"
List of Mandatory Services

Mandatory Services (Minimum Standards)		Othe	r Services	
			a, ij	. Principality
2) dobutamine				
3) nitroglycerine drip				
4) epinephrine				
b) sedatives				
1) midazolam OR				
2) propofol OR				
3) fentanyl OR	Ĭ			
4) other sedative				
E. Pre-discharge medications, laboratory,	1			
ancillary procedures				
1. CBC and platelet count				
2. Chest X-ray PAL				
3. Transthoracic echo prior to discharge				



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

### Z BENEFIT FOR CERVICAL CANCER STAGE IA1, IA2-IIA1

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

Table 1. Services included for Cervical CA, Stage IA1, IA2-IIA1, requiring surgery only					
Mandatory Services (Minimum	Other Services				
Standards)					
A. Preoperative laboratory	A. Surgery (if indicated)				
<ol> <li>CBC</li> <li>platelet count</li> <li>blood typing</li> <li>chest x-ray</li> <li>ECG</li> <li>FBS</li> <li>Na, K, Cl, Ca</li> <li>creatinine</li> <li>AST/ALT</li> <li>pro-time</li> <li>urinalysis</li> <li>histopathology</li> <li>imaging: TV-UTZ</li> </ol>	For Stage IA1 alone: Extrafascial/Total Hysterectomy with or without bilateral salpingoophorectomy  For stage 1A2 -1B1: Radical Hysterectomy with bilateral pelvic lymphadenectomy, paraortic lymph node sampling: Bilateral salpingoophorectomy OR Transposition of ovaries				
	B. Blood transfusion support				
B. Preoperative antibiotic prophylaxis	<ul> <li>C. Other preoperative laboratory</li> <li>1. Partial thromboplastin time</li> <li>2. CT scan or MRI</li> <li>3. Blood support (screening, processing)</li> <li>4. Cytoscopy</li> </ul>				
C. Follow up consultation (within 2 weeks post-procedure)	D. Postoperative Laboratory (if indicated)  a. CBC with platelet  b. ECG  c. electrolytes				
	E. Postoperative medications (as needed) a. analgesics b. antibiotics c. hematinics				



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

Mandatory Services (Minimum Standar	ds) Other Services
Radiation Treatment Summary	Blood Transfusion Support (if
<ul> <li>pelvic radiation (pelvic cobalt)</li> </ul>	indicated)
brachytherapy (low dose)	
Preoperative laboratory	Preoperative laboratory (if indicated
a. CBC	a. partial thromboplastin time
b. platelet count	b. imaging: CT scan or MRI
c. blood typing	c. blood support (screening,
d. chest x-ray	processing)
e. ECG	d. cystoscopy
f. FBS	e. proctosigmoidoscopy
g. Na, K, Cl, Ca	
h. creatinine	Postoperative Laboratory (if
i. AST/ALT	indicated)
j. pro-time	a. CBC with platelet
k. urinalysis	b. ECG
l. histopathology	c. electrolytes
m. imaging: TV-UTZ	
Chemotherapy medications	Pre-chemotherapy laboratory exams
a. cisplatin	(if indicated)
b. carboplatin	a. CBC
_	b. creatinine
Follow up consultation	c. magnesium
within 2 weeks post-procedure)	d. urinalysis
	Support Medications (if indicated)
	a. anti-emetics
	b. G-CSF
	c. hematinics
	Post treatment medications (home
	medications, if indicated)
	a. anti-emetics
	b. analgesics
	c. hematinics

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

Mandatory Services (Minimum Standards)	Other Services
Radiation Treatment Summary	Blood Transfusion Support
a. pelvic radiation (linear accelerator)     b. brachytherapy (low or high dose rate)	(if indicated)
Preoperative laboratory	Preoperative laboratory (if indicated)
a. CBC	a. partial thromboplastin time
b. platelet count	b. imaging: CT scan or MRI
c. blood typing	c. blood support, screening,
d. chest x-ray	processing
e. ECG	d. cystoscopy
f. FBS	e. proctosigmoidoscopy
g. Na, K, Cl, Ca	
h. creatinine	Postoperative Laboratory (if
i. AST/ALT	indicated)
j. pro-time	a. CBC with platelet
k. urinalysis	b. ECG
l. histopathology	c. electrolytes
m. imaging: TV-UTZ	
Chemotherapy medications	Pre-chemotherapy laboratory exams
a. cisplatin	(if indicated)
b. carboplatin	a. CBC
•	b. creatinine
Follow up consultation	c. magnesium
(within 2 weeks post-procedure)	d. urinalysis
	Support Medications (if indicated)
	a. anti-emetics
ei l	b. G-CSF
Dafe; //	c. hematinics
	Post treatment medications (home
	medications, if indicated)
1	a. anti-emetics
. [ ]	b. analgesics
<u>ن</u> ا	c. hematinics

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

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

Z Benefit Package		entil ICD-10		control control de colonia.	VS. [ de/s	RVS Description .
Acute	<b>Z</b> 001	<b>C</b> 91.0,	Acute lymphoblastic	964	408	Chemotherapy administration
lymphocytic/		M9821/3	leukaemia			
lymphoblastic				96	450	Chemotherapy administration into CNS, requiring and
leukemia						including spinal puncture

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

Z Benefit Packag	e Package Code	ICD-10.	ICD-10.	RVS Code/s	RVS Description
Breast cancer	Z002	D05.1	Intraductal carcinoma in situ of breast	19180	Mastectomy, simple, complete
Date: 122 A		C50	Malignant neoplasm of breast	19240	Mastectomy, modified radical, including axillary lymph nodes, w/ or w/o pectoralis minor muscle, but excluding pectoralis major muscle
PY				88332	Pathology consultation during surgery; with frozen section(s), two (2) or more blocks
23				88331	Pathology consultation during surgery; with frozen section(s), single block
				96408	Chemotherapy administration
				36488	Placement of central venous catheter (subclavian, jugular, or
22					other vein) (e.g., for central venous pressure,
					hyperalimentation, hemodialysis, or chemotherapy);
<del></del>					percutaneous or cutdown

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

,	Z Benefit Package	Package	ICD-10	ICD-10	RVS	RVS Description
¥.		Code	ht.4 Howell	Description	Code/s	
	Prostate cancer	Z003	C61	Malignant neoplasm	55810	Prostatectomy, perineal radical;
-63	<del>}-</del>			of prostate	55812	w/ lymph node biopsy(s) (limited pelvic
2-	<u>{                                    </u>			•		lymphadenectomy)
,	<u>4                                     </u>				55815	w/ bilateral pelvic lymphadenectomy, including external
•	ai					iliac, hypogastric and obturator nodes
اڳــ	iga la la la la la la la la la la la la la				55840	Prostatectomy, retropubic radical, w/ or w/o nerve sparing;
	<del>(2)</del>				55842	w/ lymph node biopsy(s) (limited pelvic
$\sim$	1 }					lymphadenectomy)
1	ا او				55845	w/ bilateral pelvic lymphadenectomy, including external
	3					iliac, hypogastric, and obturator nodes
	]				55866	Laparoscopy, surgical prostatectomy, retropubic radical,
	<sup>တ္တ</sup> ်					including nerve sparing

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

Z Benefit Package	, Package ? Code	ICD-10.	1CD-10 Description	RVS Code/s	RVS Description (1)
Kidney transplantation	<b>Z</b> 004	N18	Chronic renal failure	50320	Donor nephrectomy, w/ preparation and maintenance of allograft; from living donor
<b>F</b>			•	50340	Recipient nephrectomy
				50360	Renal allotransplantation, implantation of graft; excluding donor and recipient nephrectomy
				50365	w/ recipient nephrectomy
				50370	Removal of transplanted renal allograft

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

	Table 5. Summary of	codes for the	C Z DCHCH	is for colonary affery b	y pass grant	
	Z'Benefit Package	Package Code	And I seem to be a seem to be seen the	ICD±10 Description	**TRVS*** Code/s	RVS Description
	Elective surgery for coronary artery	<b>Z</b> 005	I20 I25	Angina pectoris Chronic ischaemic	33510	Coronary artery bypass, vein only; single coronary venous graft
	bypass graft		120	heart disease	33511	two coronary venous grafts
					33512	three coronary venous grafts
					33513	four coronary venous grafts
					33514	five coronary venous grafts
	_				33516	six or more coronary venous grafts
	OPY Date: 12/2/2				33517	Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (list separately in addition to code for arterial graft)
STEF	Date.				33518	two venous grafts (list separately in addition to code for arterial graft)
Σ	O P				33519	three venous grafts (list separately in addition to code for arterial graft)
	DC:				33521	four venous grafts (list separately in addition to code for arterial graft)
					33522	five venous grafts (list separately in addition to code for arterial graft)

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

Table 5. Summary of codes for the Z benefits for coronary aftery b	ypass gran	surgery, standard risk
Z Benefit Package Package ICD=10 IGD=10 Code Description	RVS** Code/s	RVS Description
	33523	six or more venous grafts (list separately in addition to
		code for arterial graft)
	33533	Coronary artery bypass, using arterial graft(s); single arterial graft
	33534	two coronary arterial grafts
	33535	three coronary arterial grafts
	33536	four or more coronary arterial grafts
	33572	Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjuction w/ coronary artery bypass graft procedure, each vessel (list separately in addition to primary procedure)

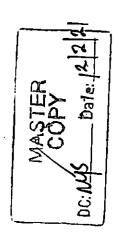


Table 6. Summary of codes for the Z benefit for Tetralogy of Fallot

Tuble of Sulfilling of Codes for the 22 b	cheff for retuiosy of runor	•	
Z Benefit Package Package : ICD	-10: - ICD-10	TRVS	RVS Description
Code Code	Description	Code/s	
Surgery for Z006 Q2	1.3 Tetralogy of Fallot	33684	Closure of ventricular septal defect, with or without patch; with
Tetralogy of Fallot	Ventricular septal		pulmonary valvotomy or infundibular resection (acyanotic)
	defect with		
2	pulmonary stenosis	33692	Complete repair of tetralogy of Fallot w/o pulmonary atresia;
<del></del>	or arterial,		
E C	dextroposition of	33694	with transannular patch
<u>a</u>	aorta and	****	
71	hypertrophy of right	33697	Complete repair of tetralogy of Fallot w/ pulmonary atresia
1 1	ventricle		including construction of conduit right ventricle to pulmonary
1 1			artery and closure of ventricular septal defect
~		33684	Closure of ventricular septal defect, with or without patch; with
<u> </u>			pulmonary valvotomy or infundibular resection (acyanotic)

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

Z Benefit Package	Package Code	10D-10	ICD-10 ··· Description	eren Sinikar da anwaren	RVS Description
Surgery for ventricular septal	<b>Z</b> 007	Q21	Congenital malformation of	33681	Closure of ventricular septal defect, w/ or w/o patch;
defect			cardiac septa		

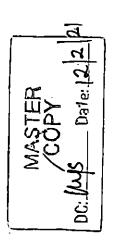
Table 8. Summary of codes for the Z benefit for cervical cancer using chemoradiation with cobalt and brachytherapy (low dose) or primary surgery for stage IA1, IA1-IIA1 as treatment modality

	Z Benefit Package	Package Code	ICD-10	ICD-10 Description	RVS Code/s	RVS Description
	Cervical cancer:	<b>Z</b> 008	C53	Malignant neoplasm	57500	Cervical biopsy
	chemoradiation			of vagina	57520	Cone biopsy
	with cobalt and				57522	LEEP
	brachytherapy (low					
	dose) or primary				96408	Chemotherapy
	surgery for stage					
	IA1, IA1-IIA1				<i>774</i> 01	Radiotherapy, pelvic cobalt
<u>-</u>	2 2				<i>777</i> 61	Brachytherapy (low dose) surface, interstitial or intracavitary
で ア ア ア	Date:(9/2/9				58150	For Stage IA1 only: Total extra fascial hysterectomy with or without bilateral salpingoophorectomy
200	900				58210	For Stage IA2-IIA1: Radical hysterectomy with bilateral pelvic lymphadenectomy and paraaortic lymph node sampling with or without bilateral salpingoophorectomy

Table 9. Summary of codes for the Z benefit for cervical cancer using chemoradiation with linear accelerator and brachytherapy

(low/high dose) as treatment modality

(10 11/ III GII GOOD) NO LI	cucincine into				
Z Benefit Package		ICD-10	ICD-10 Description	RVS Code/s	RVS Description
Cervical cancer:	Z009	C53	Malignant neoplasm	57500	Cervical biopsy
chemoradiation	23007	<i></i>	of vagina	57520	Cone biopsy
			Oi vagilia	J/ JZQ	Colle biopsy
with linear				57522	LEEP
accelerator and				•, •==	
brachytherapy				96408	Chemotherapy
				70100	Gienomerapy
(low/high dose)					
				<i>77</i> 401	Radiotherapy, linear accelerator
					70 1 1 (1 /11 1 1 ) C · · · · · · · · · · · · · · · · · ·
				<i>777</i> 61	Brachytherapy (low/high dose) surface, interstitial or
					intracavitary
					111111011111111111111111111111111111111



# Field Monitoring of the Z Benefits

Health Finance Policy Sector Philippine Health Insurance Corporation

### I. Introduction

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

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

### **Objectives**

The objectives of the field monitoring are:

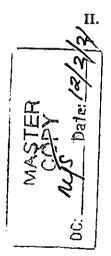
- a. Verify the services received by Z patients from the contracted HCPs;
- b. Verify if co-payments were made by members and the breakdown of co-payments;
- c. Determine satisfaction of patients on the services received from the contracted HCPs and the benefits of PhilHealth;
- d. Gather personal feedback from actual Z patients which are qualitative data that would serve as inputs to policy research and benefits enhancement.

### III. Description of the Field Monitoring

The Field Monitoring is a three-part process.

### A. Identification of Z Patients

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



### B. Process of Securing Informed Consent

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

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

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

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

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

### C. Interview Process

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

The three types of field monitoring tools of the Z benefits are the following:

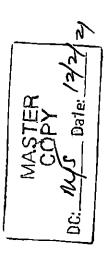
- 1. Acute lymphocytic leukemia (Annex L-ALL)
- 2. Surgery and chemoradiation (Annex L-Surgery, chemotherapy)
- 3. For surgery only (Annex L-Surgery)

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

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

Apart from the interview, photocopies of the medical charts of Z patients are obtained from the contracted HCPs. Data extraction forms will be used to assure that pertinent information from the medical charts are noted.

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



#### KOPYA PARA SA PHILHEALTH -

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

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

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

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

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

Pangalan	Edad
Pirma	Petsa (mm/dd/yyyy)
&	
A	

KOPYA PARA SA MIYEMBRO -



### Informed consent para sa field validation ng mga pasyente na nakatanggap ng z Benefits ng Philhealth

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

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

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

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

Pangalan	Edad
Pirma	Petsa (mm/dd/yyyy)



### Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444 www.philhealth.gov.ph



Annex L3

### PATIENT CONSENT TO PUBLICATION OF INFORMATION

(based on PhilHealth Office Order 0050 s. 2011)

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

Name of person shown in the photograph/video:
Subject Matter:  Z BENEFITS
Author of the AVP:
(insert full name) give my consent for this information about myself/my child or ward/my relative (circle correct description) relating to the subject matter above to appear in the photograph/video footage in full or in part and in othe publications and products published by PhilHealth in the future.
I also allow my/my child or ward/ my relative's image or video footage to be used in PhilHealth's information campaign, as long as the usage is within the proper context.
I understand that I can only revoke my consent at any time before publication, but once the information has been committed to print, it will no longer be possible for me to revoke this consent.
With this consent form, I free PhilHealth from any liabilities that may arise from publication o my/my child or ward/ my relative's image or video footage.
Name and signature:
Date signed:
Relationship to patient (if applicable):
If the patient or respondent is unable to write, affix right thumbmark:

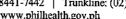


Page 1 of 1 of Annex L3



## Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

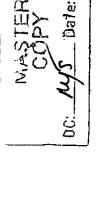
Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444 www.philhealth.gov.ph





Annex "L-ALL"

	Control Number:
Z BENEFIT FIELD VALIDATION TOOL FOR ACUTE LYMPH	HOCYTIC LEUKEMIA
READ BEFORE STARTING THE INTERVIEW:	
Magandang umaga/hapon. Una sa lahat, salamat sa pagabihin ang pangalan), naatasang isagawa ang intervatanggap ninyo bilang isa sa mga beneficiaries ng Z bang PhilHealth benefit na natanggap ninyo.	iew sa inyo para malaman ang estado ng serbisyong
Napili kayo bilang respondent sa pamamagitan ng pag Z benefit sa mga contracted hospitals. Ayon sa talaan (sabihin ang pangalan ng ospital) sa ilalim ng Z benefi	namin, kayo ay na-ospital sa
pagkaka-ospital)	Submit and persung
Isasagawa natin ang interview na ito sa mahigit kumul personal na impormasyon sa inyo maliban lang sa mga sabihin sa interview na ito ay mananatiling confidentia PhilHealth. Simulan na natin. (If with recorder, ask pe	a mahahalaga para sa Z benefit. Anuman ang inyong al at hindi makakaapekto sa membership ninyo sa
1. Name of Patient (initials):	2. Province/Municipality:
3. Educational Attainment: ☐ none	4. Age:
<ul><li>□ elementary (undergraduate)</li><li>□ elementary</li></ul>	5. Sex: ☐ male ☐ female
frespondent is not the patient	
6. Name of Respondent:  (Last name, first name, middle initial, ext.)	7. Relationship to patient: ☐ parent ☐ sibling
	☐ guardian. ☐ others: (specify)
8: Educational Attainment:	9. Age:
☐ elementary ☐-high school	10. Sex:.□ male .□ female
☐ vocational ☐ college ☐ post graduate	
☐ others: (specify)	





S	atisfac	
	11.	Kayo ba ay nasiyahan sa serbisyong natanggap ng pasyente mula sa ospital noong siya ay operahan?  I hindi (proceed to 13)  I oo
	12.	Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap niya? (proceed to 14)
		13. Kung hindi kayo nasiyahan, anu-anong dahilan? (proceed to 14)
	14.	Nag chemotherapy ba ng pasyente? ☐ hindi ☐ oo (proceed to 16)
		15. Kung hindi, ito ba ay ☐ desisyon ng mga magulang ☐ sinabi ng kanyang doktor ☐ may ibang nagpayo; sino? ☐ (proceed to 20)
	16.	Kung oo, saan isinagawa ang mga chemotherapy sessions niya?
	17.	Nasiyahan ba kayo sa serbisyong natanggap ng pasyente sa pagkakabigay ng chemotherapy?  □ hindi □ oo (proceed to 20)
en en		18. Kung hindi Kayo nasiyahan, anu-ano ang dahilan?
P	hilHea	lth Benefit:
_	19.	Nagamit ba ng pasyente ang PhilHealth ng kanyang mga magulang sa kanyang chemotherapy? $\Box$ hindi $\Box$ oo
	20.	Naipaliwanag ba sa inyo ang inyong PhilHealth benefits?  □ hindi (proceed to 22) □ oo
	21.	Gaano kalinaw ang pagkakaunawa ninyo sa inyong PhilHealth benefits?  ☐ lubos na malinaw ☐ malinaw ☐ di gaanong malinaw ☐ di ko naintindihan
	22.	Alam niyo ba kung magkano ang bill ninyo sa ospital? ☐ hindi <i>(proceed to 24)</i> ☐ oo
J	23.	Kung oo, magkano ang kabuuang bill ninyo sa ospital?



24.	Noong nag-chemothera a. may ipinabili b	npy ang pasyente, a sa inyong gamot sa labas	ng ospital?	□ wala □ mayroon □ NA
		ang gamit sa inyo sa labas i ulak, gasa, alcohol)	ng ospital?	□ wala □ mayroon □ NA
	c. may ipinagawa	ang lab test ba sa inyo sa lal	oas ng ospital?	□ wala □ mayroon □ NA
25.	May binayaran ba kayo	ng professional fee ng dokt	or? 🗆 wala 🗀 mayro	on
26.	May mga binayaran pa □ wala □ mayroon, a	ba kayong iba bukod sa mg nu-ano ang mga ito?	a nabanggit sa itaas?	
27.		ga resibo ng inyong binili o la <i>proceed to 31</i> may		
28.	Kung mayroon kayong rito?	naitagong mga resibo ng iny d to 31 🔲 oo 🔲 N	ong pinagbayaran, ma A <i>proceed</i> to 31	aari bang makita ang mga
29.	Kung oo, maaari bang h ☐ hindi <i>proceed to 31</i> Kung <i>oo,</i> ilista ang mga		ta ang mga ito? oceed to 31	
30.	a. Medicines:			
50.	Generic name	No. of units	Unit cost	Total cost
			<del></del>	
<u>`</u>				
				<u>.                                    </u>
1	b. Supplies:	No. of units	Unit cost	Total cost
		THOSE GRANTES		Total cost
1	-		_	
]				
	-			



Revised as of November 2021

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		c. Diagnostics/labora	tory examina		
		Diagnostics/lab exams	No. of times	Unit cost	Total
			·		
			<u> </u>	<del> </del> -	
	_	<del></del>			_
		<del></del> .	<del> </del>		
		<del></del>		<del> </del>	
				<u> </u>	
		d. Professional Fees:			
		Initials	Specia	altv	Amount
			5,700.0		-
	-				
				□ sariling sasaky □ nirerentahan	an
A.		ari niyo bang isalarawan nggap mula sa ospital at	ang inyong kabuuang ka	□ nirerentahan aglakad lang asiyahan sa mga serbis	
COPY (2/2/2/		nggap mula sa ospital at	ang inyong kabuuang ka sa PhilHealth? (Markaha	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓)	syo at benepisyong inyo
00/2		nggap mula sa ospital at	ang inyong kabuuang ka	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓)	
DC: 14 Date: (2/2/2/	nata	nggap mula sa ospital at	ang inyong kabuuang ka sa PhilHealth? (Markaha Nasiyahan	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan	ayo at benepisyong inyo □ Di nasiyahan
00/2	nata	Lubos na nasiyahan	ang inyong kabuuang ka sa PhilHealth? (Markaha  Nasiyahan  hi para mapabuti pa ang	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan g benepisyo ng mga mi	Di nasiyahan
00/2	nata	Lubos na nasiyahan	ang inyong kabuuang ka sa PhilHealth? (Markaha Nasiyahan hi para mapabuti pa ang	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan g benepisyo ng mga mi	Di nasiyahan
00/2	nata	Lubos na nasiyahan	ang inyong kabuuang ka sa PhilHealth? (Markaha  Nasiyahan  hi para mapabuti pa ang	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan g benepisyo ng mga mi	Di nasiyahan
00/2	nata	Lubos na nasiyahan	ang inyong kabuuang ka sa PhilHealth? (Markaha Nasiyahan hi para mapabuti pa ang	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan g benepisyo ng mga mi	Di nasiyahan
00/2	nata	Lubos na nasiyahan	ang inyong kabuuang ka sa PhilHealth? (Markaha Nasiyahan hi para mapabuti pa ang	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan g benepisyo ng mga mi	Di nasiyahan
DC: VCO	a3. May	Lubos na nasiyahan	ang inyong kabuuang ka sa PhilHealth? (Markaha  Nasiyahan  hi para mapabuti pa ang	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan g benepisyo ng mga mi	Di nasiyahan
Inte	nata  33. May  erviewer: _ cumenter:	Lubos na nasiyahan	ang inyong kabuuang ka sa PhilHealth? (Markaha  Nasiyahan  hi para mapabuti pa ang	□ nirerentahan aglakad lang asiyahan sa mga serbis an ng ✓) □ Di gaanong nasiyahan g benepisyo ng mga mi	Di nasiyahan





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Annex "L-Surgery, Chemotherapy"

	Control Number:			
BENEFIT FIELD VALIDATION TOOL FOR:				
READ BEFORE STARTING THE INTERVIEW:	-			
Magandang umaga/hapon. Una sa lahat, salamat sa pa (sabihin ang pangalan), naatasang isagawa ang intervienatanggap ninyo bilang isa sa mga beneficiaries ng Z beang PhilHealth benefit na natanggap ninyo.	ew sa inyo para malaman ang estado ng serbisyong			
Napili kayo bilang respondent sa pamamagitan ng pagg Z benefit sa mga contracted hospitals. Ayon sa talaan i (sabihin ang pangalan ng ospital) sa ilalim ng Z benefit pagkaka-ospital)	namin, kayo ay na-ospital sa			
Isasagawa natin ang interview na ito sa mahigit kumula personal na impormasyon sa inyo maliban lang sa mga sabihin sa interview na ito ay mananatiling confidential PhilHealth. Simulan na natin. (If with recorder, ask per	mahahalaga para sa Z benefit. Anuman ang inyong at hindi makakaapekto sa membership ninyo sa			
1. Name of Patient (initials):	2. Province/Municipality:			
3. Educational Attainment:	4. Age:			
<ul><li>☐ elementary</li><li>☐ high school</li><li>☐ vocational</li></ul>	5. Sex: □ male □ female			
<ul><li>☐ college</li><li>☐ post graduate</li><li>☐ others: (specify)</li></ul>				
espondent is not the patient				
6. Name of Respondent: (Last name: first name, middle initial, ext.)	7. Relationship to patient:  ☐ spouse ☐ parent ☐ child ☐ sibling ☐ guardian ☐ others: (specify)			
8. Educational Attainment:	9. † Age:			
☐ elementary	10. Sex: ☐ male. ☐ female			

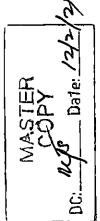


1. 5°			at mademark to					
<u> </u>				ip status of pati	ient: 🏻 member	- □ dependo	ent	
		□ single □ legall □ not le	status of the p e ly married egally married w/ widower					
I	Employn 13.		tus: ay isang empl	evado.	□ hindi	□ oo <i>(t</i>	proceed to 15)	
_							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
and the second s		14.	Kung hindi, ka	ayo ba ay:	□ may nat	iling negosyo atanggap na re	gular na suporta	mula sa
					pamilya Diba pa: _	a o kamag-anak		
				in it.		- TO THE RESERVE OF THE PARTY O		<u>.</u> 1. 33 282 € 1. <b>0.</b>
	16.	□ hindi	i <i>(proceed to :</i> yo ay nasiyaha	-	inyong ikinasiya t			
	16.	□ hindi Kung kay (proceed	(proceed to a	an, anu-ano ang		ungkol sa serbi	syong natanggal	
	16.	□ hindi Kung kay (proceed	(proceed to a	an, anu-ano ang	inyong ikinasiya t	ungkol sa serbi	syong natanggal	
	16.	□ hindi Kung kay (proceed	(proceed to a	an, anu-ano ang	inyong ikinasiya t	ungkol sa serbi	syong natanggal	
ke/c/p/	16.	□ hindi Kung kay (proceed	yo ay nasiyaha d to 18)  Kung hindi ka	an, anu-ano ang	inyong ikinasiya t	ungkol sa serbi	syong natanggal	
ale: 14/2/24	16.	□ hindi Kung kay (proceeco	yo ay nasiyaha d to 18)  Kung hindi ka	an, anu-ano ang yo nasiyahan, a	inyong ikinasiya ti nu-anong dahilan	ed to 20)	syong natanggal	
- Daie: 14/2/2	16.	□ hindi Kung kay (proceeco	yo ay nasiyaha d to 18)  Kung hindi ka	yo nasiyahan, antherapy?  hir	inyong ikinasiya ti nu-anong dahilan ndi	ungkol sa serbi ? (proceed to 1 ed to 20) syon	syong natanggal	
Daie: 14/2/2	16.	□ hindi Kung kay (proceeco	yo ay nasiyaha d to 18)  Kung hindi ka ay nag chemo	yo nasiyahan, and therapy?  hir	inyong ikinasiya ti nu-anong dahilan ndi  oo <i>(proces</i> sarili ninyong desi sinabi ng inyong d may ibang nagpay	ungkol sa serbi ? (proceed to 1 ed to 20) syon loctor /o; sino?	syong natanggal	o7
Daile: 14/2/2	18.	□ hindi Kung kay (proceed	yo ay nasiyaha d to 18)  Kung hindi ka ay nag chemo Kung hindi, it	an, anu-ano ang yo nasiyahan, a otherapy?  hir	inyong ikinasiya ti nu-anong dahilan ndi	ed to 20) syon syon cortor /o; sino?	syong natanggal	o7
	18.	□ hindi Kung kay (proceed	yo ay nasiyaha d to 18)  Kung hindi ka ay nag chemo Kung hindi, it	an, anu-ano ang yo nasiyahan, a otherapy?  hir	inyong ikinasiya ti nu-anong dahilan ndi  oo <i>(proces</i> sarili ninyong desi sinabi ng inyong d may ibang nagpay	ed to 20) syon syon cortor /o; sino?	syong natanggal	o7
Daie: 14/2/2	18. 20.	□ hindi Kung kay (proceed  17.  Kayo ba  19.  Kung oo	yo ay nasiyaha d to 18)  Kung hindi ka ay nag chemo Kung hindi, it (proceed to 2	an, anu-ano ang yo nasiyahan, a  therapy?  hir to ba ay	inyong ikinasiya ti nu-anong dahilan ndi	ed to 20) syon loctor /o; sino?	syong natanggal	27
	16. 18. 20.	□ hindi Kung kay (proceed)  17.  Kayo ba  19.  Kung oo  Nasiyahi □ hindi	Kung hindi ka ay nag chemo Kung hindi, it (proceed to 2 , saan isinagay an ba kayo sa	an, anu-ano ang yo nasiyahan, a yo hasiyahan, a otherapy?  hir to ba ay	inyong ikinasiya ti nu-anong dahilan ndi  oo (proces sarili ninyong desl sinabi ng inyong d may ibang nagpay motherapy session	ed to 20) syon loctor /o; sino?	syong natanggal	
	16. 18. 20.	□ hindi Kung kay (proceed)  17.  Kayo ba  19.  Kung oo  Nasiyahi □ hindi	Kung hindi ka ay nag chemo Kung hindi, it (proceed to 2 , saan isinagay an ba kayo sa	yo nasiyahan, and therapy? I him to ba ay.  ya ang mga che seed to 23)	inyong ikinasiya ti nu-anong dahilan ndi	ed to 20) syon loctor /o; sino? ns ninyo?	syong natanggal	
	16. 18. 20.	□ hindi Kung kay (proceed)  17.  Kayo ba  19.  Kung oo  Nasiyahi □ hindi	Kung hindi ka ay nag chemo Kung hindi, it (proceed to 2 , saan isinagay an ba kayo sa	an, anu-ano ang yo nasiyahan, a yo hasiyahan, a otherapy?  hir to ba ay	inyong ikinasiya ti nu-anong dahilan ndi  oo (proces sarili ninyong desl sinabi ng inyong d may ibang nagpay motherapy session	ed to 20) syon loctor /o; sino?	syong natanggal	



### PhilHealth Benefit:

23.	Nagami	t niyo ba ng inyong PhilHealth sa inyong operasyon? 🏻 🗈	nindi 🗆 oo
24.	Nagami	it niyo ba ng inyong PhilHealth sa inyong chemotherapy?	□hindi □ oo □ NA
25.		wanag ba sa inyo ang inyong PhilHealth benefits? i <i>(proceed to 27)</i> oo	
26.	□ lubo: □ mali: □ di ga	kalinaw ang pagkakaunawa ninyo sa inyong PhilHealth be s na malinaw naw anong malinaw naintindihan	enefits?
27.	Alam ni	yo ba kung magkano ang bill ninyo sa ospital? 🛘 hindi 👍	proceed to 29) 🗆 oo
28.	Kung o	o, magkano ang kabuuang bill ninyo sa ospital?	
29.	Habang a.	kayo ay naka-admit, may ipinabili ba sa inyong gamot sa labas ng ospital?	□ wala □ mayroon
	b.	may ipinabili bang gamit sa inyo sa labas ng ospital? (halimbawa: bulak, gasa, alcohol)	□ wala □ mayroon
	c.	may ipinagawang lab test ba sa inyo sa labas ng ospital?	□ wala □ mayroon
30.	Noong a.	kayo ay nag-chemotherapy, may ipinabili ba sa inyong gamot sa labas ng ospital?	□ wala □ mayroon □ NA
	b.	may ipinabili bang gamit sa inyo sa labas ng ospital? (halimbawa: bulak, gasa, alcohol)	🗆 wala 🗆 mayroon 🗀 NA
	c.	may ipinagawang lab test ba sa inyo sa labas ng ospital?	□ wala □ mayroon □ NA
31.	May bi	nayaran ba kayong professional fee ng doctor? 🛘 wala 🛚	□ mayroon
32.		ga binayaran pa ba kayong iba bukod sa mga nabanggit sa 🔲 mayroon, anu-ano ang mga ito?	
33.		o ba ninyo ng mga resibo ng inyong binili o kaya ay may ko an? □ wala <i>proceed to 37</i> □ mayroon □ NA <i>pro</i>	
34.		ayroon kayong naitagong mga resibo ng inyong pinagbay  I hindi <i>proceed to 37</i> I oo I NA <i>proceed to</i>	
35.		o, maaari bang humingi ng pahintulot na ilista ang mga iti	0?





#### a. Medicines: 36.

Generic name	No. of units	Unit cost	Total cost
			)
			1
		<u></u>	
		•	
-		-	
_			

ltem	No. of units	Unit cost	Total cost
item	140: 01 411163		100010030
	<del></del>	<del>-</del>	
•			
	<del>   </del>	-	<del></del>
		<u> </u>	

c. Diagnostics/laboratory exams:

Diagnostics/lab exams	No. of times	Unit cost	Total
Diegnostics, iais citatio			
<del></del>			
	<del>_</del>		
, and the second			
			<u> </u>

d. Professional Fees:

Initials	Specialty	Amount



	no ang gamit ninyong sa a. Ospital		public , specify	
	1		private specify	
			☐ sariling sasal	
			☐ nirerentahar	
			☐ naglakad lang	
	b. pasilidad ng chemotherapy		public, specify	
	b. pasiiidad ii	6 chemotherupy	private specify	
			☐ sariling sasal	
			☐ nirerentahar	
			naglakad lang	
	yong natanggap mula sa		ang kasiyahan sa mga serb th? (Markahan ng 🗸)	
	☐ Lubos na nasiyahan	☐ Nasiyahan	☐ Di gaanong nasiyahan	☐ Di nasiyahan
2. M 	lay nais ba kayong imun	gkahi para mapabuti p	oa ang benepisyo ng mga	miyembro ng PhilHealt
				<del></del>
	r:		Date of Interview	(mm/dd/yyyy):
mente	er:			
imente ograpi			Time of Interview	







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			Annex "L-Surgery
Z BENEFI	T FIELD VALIDATION TOOL FOR:		Control Number:
_			
	ey transplantation		cted orthopedic implants
	tate cancer		tricular septal defect
□ Coro	nary artery bypass graft	□ letr	alogy of Fallot
READ B	EFORE STARTING THE INTERVIEW:		
Magan	dang umaga/hapon. Una sa lahat, sa	alamat sa pagpapaui	nlak ninyo sa interview na ito. Ako si
			o para malaman ang estado ng serbisyong
natang	gap ninyo bilang isa sa mga beneficia	ries ng Z benefit pa	ckage at malaman din kung naging sapat ba
ang Phi	lHealth benefit na natanggap ninyo.		
Napili k	ayo bilang respondent sa pamamagi	tan ng pagpili ng co	mputer sa mga pasyente na naka-avail na ng
Z benef	it sa mga contracted hospitals. Ayor	n sa talaan namin, k	ayo ay na-ospital sa
(sabihir	n <i>ang pangalan ng ospital)</i> sa ilalim n	ıg Z benefit noong _	(sabihin ang petsa ng
pagkak	a-ospital)		
	sa interview na ito av mananatiling /	confidential at hindi	laga para sa Z benefit. Anuman ang inyong
	sa interview na ito ay mananatiling out the simulan na natin. (If with record Name of Patient (initials):	der, ask permission	makakaapekto sa membership ninyo sa
PhilHea	lth. Simulan na natin. (If with record	der, ask permission	makakaapekto sa membership ninyo sa first).
PhilHea 1.	Name of Patient (initials):  Educational Attainment:  none	der, ask permission . 2.	makakaapekto sa membership ninyo sa first).  Province/Municipality:
PhilHea 1.	Name of Patient (initials):  Educational Attainment:  none elementary	der, ask permission . 2.	makakaapekto sa membership ninyo sa first).  Province/Municipality:
PhilHea 1.	Name of Patient (initials):  Educational Attainment:  none elementary high school	der, ask permission 2. 4.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:
PhilHea 1.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational	der, ask permission 2. 4.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:
PhilHea 1.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college	der, ask permission 2. 4.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:
PhilHea 1.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate	der, ask permission 2. 4.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:
PhilHea 1.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college	der, ask permission 2. 4.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:
1. 3.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate others: (specify)	der, ask permission 2. 4.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:  Sex:
1. 3.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate others: (specify)  dent is not the patient  Name of Respondent:	der, ask permission 2. 4. 5.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:  Sex:
1. 3.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate others: (specify)	der, ask permission 2. 4. 5.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:  Sex: □ male □ female  Relationship to patient: □ spouse
1. 3.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate others: (specify)  dent is not the patient  Name of Respondent:	der, ask permission 2. 4. 5.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:  Sex:
1. 3.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate others: (specify)  dent is not the patient  Name of Respondent:	der, ask permission 2. 4. 5.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:  Sex: □ male □ female  Relationship to patient: □ spouse □ parent □ child
1. 3.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate others: (specify)  dent is not the patient  Name of Respondent:	der, ask permission 2. 4. 5.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:  Sex:
1. 3.	Name of Patient (initials):  Educational Attainment:  none elementary high school vocational college post graduate others: (specify)  dent is not the patient  Name of Respondent:	der, ask permission 2. 4. 5.	makakaapekto sa membership ninyo sa first).  Province/Municipality:  Age:  Sex: □ male □ female  Relationship to patient: □ spouse □ parent □ child



8	Educational Attainm  none elementary high school vocational college post graduate others: (specify)		10. S		le □ female	
	PhilHealth members     Marital status of the             □ single             □ legally married             □ not legally marrie             □ widow/ widower	patient:	<b>nt</b> : ⊔ member	□ dep€	endent	
	yment status: . Kayo ba ay isang emp	oleyado:	I	□ hindi	□ oo (proceed to	15)
Satisfa 15	ction:  Kayo ba ay nasiyahar  hindi (proceed to	ı sa serbisyong nat		□ may na mula s □ iba pa:	iling negosyo tatanggap na regula a pamilya o kamag-	anak
16	Kung kayo ay nasiyah (proceed to 18)	an, anu-ano ang ir	iyong ikinasiya tu	ngkol sa se	erbisyong natangga	o?
		ayo nasiyahan, anu	AASTEVAL	(proceed i	to 18)	
	alth Benefit:				<u>* * * * * * * * * * * * * * * * * * * </u>	
19	<ul> <li>Nagamit niyo ba ng il</li> <li>Naipaliwanag ba sa il</li> <li>I hindi (proceed to)</li> <li>Gaano kalinaw ang p</li> <li>I lubos na malinaw</li> </ul>	nyo ang inyong Phi 21) 🛭 oo	lHealth benefits?			



21.	. Alam niyo ba kung magkano ang bill ninyo sa ospital? 🏻 hindi <i>(proceed to 23)</i> 🔻 oo					
22.	Kung oo, magkano ang kabuuang bill ninyo sa ospital?					
23.	a. may ipinabili ba sa inyong gamot sa labas ng ospital?					
	b. may ipinabili bang gamit sa inyo sa labas ng ospital?  (halimbawa: bulak, gasa, alcohol) □ wala □ mayroon					
	c. may ipinagawai	ng lab test ba sa inyo sa lab	oas ng ospital?	□ wala □ mayroon		
24.	May binayaran ba kayon	g professional fee ng doct	or? 🗆 wala 🗀 mayroo	on		
25.		a kayong iba bukod sa mg u-ano ang mga ito?				
26.		e resibo ng inyong binili o koceed to 30				
27.	Kung mayroon kayong nito?	aitagong mga resibo ng iny <b>i to 30</b>	ong pinagbayaran, maa A <i>proceed to 30</i>	aari bang makita ang mga		
28.	28. Kung oo, maaari bang humingi ng pahintulot na ilista ang mga ito? ☐ hindi proceed to 30 ☐ oo ☐ NA proceed to 30  Kung oo, ilista ang mga detalye sa ibaba.					
29.	a. Medicines:					
	Generic name	No. of units	Unit cost	Total cost		
<del>-</del>						
	b. Supplies:					
	Item	No. of units	Unit cost	Total cost		
•						
1			<del></del> -	<del>                                     </del>		



	d. Professional Fe		ialty	Amount
	initials	Spec	Tally .	741104111
30.	Ano ang gamit ninyong s Ospital	Ī	☐ public , specify	
31.	Maaari niyo bang isalara (Markahan ng ✔)		□ sariling sasaky □ nirerentahan □ naglakad lang g kasiyahan sa serbisyong	
2/2/2				
ii   32.	☐ Lubos na nasiyahan May nais ba kayong imu	□ Nasiyahan ngkahi para mapabuti pa	□ Di gaanong nasiyahan ang benepisyo ng mga m	□ Di nasiyahan iyembro ng PhilHealt
DC: 72				
	ver: nter:		Date of Interview	(mm/dd/yyyy):
Photogra	apher/Videographer: ader:		Time of Interview	<i>י</i> :

No. of times

Unit cost

Total

c. Diagnostics/ laboratory exams:

Diagnostics/lab exams





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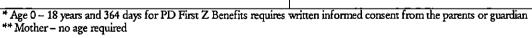
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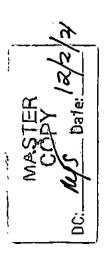


Annex "N"

# Summary of age requirements to avail of the Z Benefits

Z Benefit Package	Age
A. Acute Lymphocytic / Lymphoblastic Leukemia (ALL)	1 to 10 years and 364 days
B. Early Breast Cancer (Stage 0 – IIIA)	None required
C. Standard Risk Coronary Artery Bypass Graft (CABG) Surgery	At least 19 years of age
D. Cervical Cancer	None required
E. Kidney Transplant	None required
F. Prostate Cancer	None required
G. Colon Cancer	None required
H. Rectum Cancer	None required
I. ZMORPH	At least 18 years
J. Expanded ZMORPH	At least-18 years
K. Peritoneal Dialysis First*	None required
L. Tetralogy of Fallot	1 to 10 years and 364 days
M. Ventricular Septal Defect	1 to 10 years and 364 days
N. Selected Orthopedic Implants	None required
O. Premature and Small Newborn**	24 weeks to <37 weeks for newborns
P. Children with Developmental Disability	0 – 17 years and 364 days old
Q. Children with Mobility Impairment	0 – 17 years and 364 days old
R. Children with Visual Impairment	0 – 17 years and 364 days old
S. Children with Hearing Impairment	0 – 17 years and 364 days old











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## Annex "O - Breast Cancer Medical Records Summary"

HEALTH CARE PROVIDER (HCP)			
ADDRESS OF	HCP		
A. PATIENT	1. Last Name, First Nam	ne, Middle Name, Suffix	SEX  Male Female
	2. PhilHealth ID Numb	per	
B. MEMBER		er the following only if the patient is a dependence ne, Middle Name, Suffix	nt)
ah Tipa ketika	2. PhilHealth ID Numb	ver -	
BREAST CANCER MEDICAL RECORDS SUMMARY FORM  Instructions: This form is required for all breast cancer mortalities and "lost to follow-up1" patients in contracted health care institutions. Completely fill-out all required items. Submit this form as attachment to claims for the 2nd tranche.  Breast Cancer Disease Profile  Laterality of breast cancer (Choose one Right by ticking the appropriate box)  Left Both  Not recorded in the chart  Biopsy Histological Diagnosis (Verbatim from histopathology report)			
Date of biopsy		Date (mm/dd/yyyy)	
Clinical Cancer	Stage at pre- Choose one by ticking	I CIS	
the appropriate	box)	IIA	
		IIB	
		IIIA	
		Not recorded in the chart	



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

With data



TNM (Choose one by ticking the appropriate box)

Date of post-surgical histopathologic	(IIIII) dd/ yyyy)
report	
Histological/nuclear grade (Choose	GX: Grade cannot be assessed (undetermined
one by checking the appropriate box)	grade)
	G1: well-differentiated (low grade)
	G2: moderately differentiated (intermediate grade
	G3: poorly differentiated (high grade)
	G4: undifferentiated (high grade)
	Not recorded in the chart
Pathological Cancer Stage (Choose one	CIS
by checking the appropriate box)	I
	IIA
	IIB
	IIIA
	IIIB
	IV
	Not recorded in the chart
Provide the appropriate information	What is T?
for TNM	What is N?
	What is M?
	Not recorded in the chart
Widest diameter of primary tumor	(cm) or (mm)
	Not recorded in the chart
Number of positive lymph	positive lymph nodes
nodes/TLNs harvested	TLNs
	Not recorded in the chart
Lymphovascular invasion (Choose one	Negative
by checking the appropriate box)	Positive
	Not recorded in the chart
Daving supplier version (Change and her	
Perineural invasion (Choose one by	Negative
checking the appropriate box)	Positive
	Not recorded in the chart
Surgical margin involvement (Choose	Negative
one by checking the appropriate box)	Positive
	Not recorded in the chart
Were tumor markers done? (Choose	Yes
one by checking the appropriate box)	No
5 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Not recorded in the chart
ER	
	Negative 1997 Alf 1
(Choose one by checking the appropriate box)	Positive: % (1% to 100%); Alfred score
	Not recorded in the chart
PR	Negative
(Choose one by checking the	Positive:% (1% to 100%); Alfred score
appropriate box)	Not recorded in the chart

(mm/dd/yyyy)

Date of post-surgical histopathologic





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

### II. Breast Cancer Treatment Profile

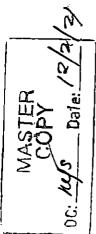
	Was definitive surgery done? (Choose one by	Yes
ĺ	checking the appropriate box)	No
		No operative record in the chart
	If yes, what is the name of the surgical procedure?	
ł	Was chemotherapy given in the contracted	Yes
	health care institution? (Choose one by	No
	checking the appropriate box)	No record found in the contracted health care institution
		Chemotherapy was given by another healthcare provider
	If answer to previous question is "no," check the appropriate box and must provide details.	Patient preference
		Advised by healthcare provider
		Patient is "lost to follow-up1"
	If answer is "yes," specify the drug regimen used.	
. (	Specify the total dose per cycle for the drug regimen used (Choose one by checking the	Total dose per cycle:
	appropriate box)	Not recorded in the chart
	If chemotherapy was given, provide the date	mm/dd/yyyy
	when chemotherapy started (Choose one by checking the appropriate box)	Not recorded in the chart
-		NA, chemotherapy was not given
	If chemotherapy was given, how many cycles were given? (Choose one by checking the appropriate box)	NA, chemotherapy was not given

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



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What is the purpose of chemotherapy?	s 1°
(Choose one by checking the appropriate box)	Adjuvant
(Choose one by checking the appropriate box)	Neo-adjuvant
	NA, chemotherapy was not given
What is tumor response to chemotherapy?	NED (no evidence of disease progression)
(Choose one by checking the appropriate box)	CR
	PR
	SD
	PD (progressive disease)
	Not recorded in the chart
Was the chemotherapy regimen ever changed?	NA, chemotherapy was not given
was the chemotherapy regimen ever changedr	Yes
	No
	Not recorded in the chart
	NA, chemotherapy was not given
What is reason for chemotherapy regimen is	Adverse event to former chemotherapy.
changed?	Specify adverse event:
	PD
	Patient preference
	Other (Specify):
	Not recorded in the chart
	NA, chemotherapy was not given
What drug/s were used in this new	
chemotherapy regimen?	
Specify the total dose per drug per cycle for	Total dose per drug per cycle:
this new drug regimen used	1 01 ,
	Not recorded in the chart
What is the start date for this new	mm/dd/yyyy
chemotherapy regimen?	
How many cycles were given for this new	,
chemotherapy regimen?	
What is the purpose for this new	Adjuvant
chemotherapy regimen?	Neo-adjuvant
	Palliative
	Not recorded in the chart
What is tumor response for this new	NED
chemotherapy regimen? (Choose one by	CR CR
checking the appropriate box)	PR
	SD
	PD
	Not recorded in the chart
Was radiotherapy advised?	
was radionicrapy advised:	Yes, it is recorded in the chart
	No, it is recorded in the chart
	It is not documented in the chart





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

### III. Breast Cancer Survival Status

[	Date of survival assessment	mm/dd/yyyy
	What is the status of this patient at this date	Alive
	•	Died
		Lost to follow-up <sup>1</sup>
I		Not recorded in the chart
	When was date of last follow-up?	mm/dd/yyyy
		Not recorded in the chart
	What is the status of this patient at this last	Alive, NED
_	follow-up date?	Alive with residual small lesions, on
†		definitive treatment
$\left  \cdot \right $	1	Alive with residual small lesions, without
;		definitive treatment
5		Alive with residual big lesions, on definitive
7		treatment
		Alive with residual big lesions, without
		definitive treatment
		Alive with terminal disease, only on
		supportive treatment
		Not recorded in the chart
	If died, when was date of death?	mm/dd/yyyy
		Not recorded in the chart
	If died, what is cause of death?	Breast cancer-related
		Not cancer-related
		Not recorded in the chart

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





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	Case No				Annex "P -	- Additional Services"
	LIST	r of additi	ONAL SERVICI	ES FOR CO	OMPLICAT	ED CASES
	HEALTH CAL	RE PROVIDER	. (HCP)			
	ADDRESS OF	НСР			_	
	A.PATIENT	1. Last Name,	First Name, Midd	e Name, Su	Iffix==	SEX  Male   Female
		2. PhilHealth			3 7 1	
	B. MEMBER	☐ Same as patient  1. Last Name,	(Answer the following First Name, Midd	e Name, Su	it is a dependent) iffix	
	· · · · · · · · · · · · · · · · · · ·	2. PhilHealth	ID Number	, pr		
	they assessed	to be complica	ted in order to p	rovide Phil	Health pertii	provider for cases which nent data on additional Use additional sheets if
7	Diagnost	ics/Labs	Indicatio	n ,	Frequency	Hospital charge/Amount(Php)
MASTER COPY M/S Date: /?	The state of the s					Charge/Timouni(111p)
<u></u>	Procee	dure/s	Indication	on	Frequency	Hospital charge/Amount(Php)
						charge/ Annount(Fitp)



Drug/s (Generic and Brand Name)	Indicatio		No. of units consumed	Hospii charge/Amo	tal unt(Php)
Sub-specialty Referral	Reason	/s for referr	The second secon	Professional:	fee (Php)
n ne ne ne ne ne ne ne ne ne ne ne ne ne					
Other services	In	dication		Hospi charge/Amo	tal unt(Php)
				, 4 , 2 , 3 , 4 , 4	
	_ Terr		f _ f		
Certified correct by:	A CONTRACT OF THE CONTRACT OF	Certified co	orrect by:		
(Printed name and signature (Printed name and signature) Attending Physics	gnature) ian	Execut Medica	ive Directo	e and signature) r/Chief of Hos Medical Center	pital/
PhilHealth Accreditation No.		PhilHealth Accreditation No	).		
	<del>, , , , , , , , , , , , , , , , , , , </del>				·





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Annex "Q"

# Summary of validity of approved pre-authorization for the Z Benefits

Z Benefit Package	Validity Period (Calendar days)
Acute Lymphocytic / Lymphoblastic     Leukemia	60 days
2. Early Breast Cancer (Stage 0-IIIA)	60 days
3. Standard Risk Coronary Artery Bypass Graft (CABG) Surgery	- 180 days
4. Cervical Cancer	60 days
5. Colon Cancer	60 days
6. Rectal Cancer	60 days
7. ZMORPH	180 days
8. Expanded ZMORPH	180 days
9. Kidney Transplant	180 days
10. Peritoneal Dialysis (PD) First	60 days.
11. Tetralogy of Fallot (TOF)	180 days
12. Ventricular Septal Defect	180 days
13. Prostate Cancer	60 days
14. Selected Orthopedic Implants	60 days
15. Children with Mobility Impairment	180 days
16. Children with Visual Impairment	180 days

_		N
	MASTER	)C. 100/8 Date: /2/2/

Z Benefit Package	Validity Period (Fiscal Year)
17. Children with Developmental Disability	1 Fiscal Year
18. Children with Hearing Impairment	1 Fiscal Year





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Annex "R"

### Summary of Tranche Payments for the Z Benefits

## I. Acute Lymphocytic / Lymphoblastic Leukemia

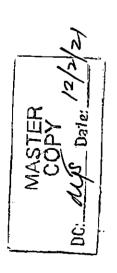
Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
-		
1 <sup>st</sup>	300,000,00	Within 60 days after the discharge after
		the end of induction phase
2 <sup>nd</sup>	125,000.00	Within 60 days after the end of
	a service of the serv	intensification or re-induction phase
3 <sup>rd</sup>	75,000.00	Within 60 days after the 6th maintenance
<u>.</u>		cycle

## II. Breast Cancer

Order of Tranche	Amount (Php)	Deadline of submission of claims
Payment		
1 <sup>st</sup>	75,000.00	Within 60 days after discharge from
fi ,		surgery _
, 2 <sup>nd</sup>	25,000.00	Within 60 days upon completion of last
1 1	* 12* ;	cycle of chemotherapy for Stage I to IIIA
<u> </u>		or upon completion of surgery for Stage 0

### III. Coronary Artery Bypass Graft (CABG) Surgery

Order of Tranche	Amount (Php)	Deadline of submission of claims
Payment		
1 <sup>st</sup>	500,000.00	Within 60 days after discharge after the
		surgery
2 <sup>nd</sup>	50,000.00	Within 60 days after the first follow up, one week post discharge (to check the vital signs and hemodynamic status, operative site, wound care, continuation of cardiac rehabilitation OPD phase of program)



### IV. Cervical Cancer

A. Cervical Cancer Chemoradiation with Cobalt & Brachytherapy (Low Dose) or Primary Surgery for Stage IA1, IA2-IIA1

Order of Tranche	Amount (Php)	Deadline of submission of claims
Payment	, vš.,	
1st	125,000.00	Within 60 days after discharge from
	ا به معنی میشود. از معنی میشود میشود از این این این این این این این این این این	surgery for primary surgery or from the
	A CONTRACTOR OF THE PROPERTY O	first follow up without complications
	Jackson of the profession of the same	(pelvic exam done) if with chemoradiation

B. Cervical Cancer chemoradiation with Linear accelerator and brachytherapy

Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
1st // //	175,000.00	Within 60 days after the first follow up without complications (pelvic exam done)

V. End Stage Renal Disease Eligible for Kidney Transplant (Low Risk)

Order of Tranche Payment		Deadline of submission of claims
15t	550,000.00	Within 60 days upon discharge of recipient after the transplantation
2 <sup>nd</sup>	50,000.00	Ninety (90) days after the transplantation

### VI. PD First Z Benefits

Number of Tranche Payment		Deadline of submission of claims
26 Tranches	10, 384.60 / tranche	Within 60 days after every 14th day of PD exchanges

#### VII. **Prostate Cancer**

	Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
ı	1 <sup>st</sup>	100,000.00	Within 60 days after discharge from surgery





As of November 2021

# VIII. Tetralogy of Fallot

Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
1 <sup>st</sup>	270,000.00	Within 60 days after discharge from surgery
2 <sup>nd</sup>	50,000.00	Rehabilitation Exercise Sessions (3rd and 4th

# IX. Ventricular Septal Defect

Order of Tranche	Amount (Php)	Deadline of submission of claims
Payment /	,	1
1st	200,000.00	Within 60 days after discharge from surgery
2 <sup>nd</sup>	50,000.00	Within 60 days after completion of
		Rehabilitation exercise session (3rd -4th session in the first week post-op







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Annex "S"

# Definitions of "lost-to-follow-up" patients availing of the Z Benefits

It is the responsibility of contracted health care providers to look out for the best interest of their patients. Before declaring their patients lost-to follow-up, contracted health care providers should exert best reasonable effort to reach their patient or the patient's family and ascertain the reason for the discontinuance of care.

The declaration of lost-to-follow-up patients are applicable to all Z Benefits that require continuing mandatory services such as those for chemotherapy, radiation therapy, rehabilitation and provision of peritoneal dialysis solutions. The following table contains specific definitions of lost-to-follow-up patients for particular Z Benefit packages.

- t			
	1.	Early Breast Cancer (Stage 0- IIIA)	Patient has not come back as advised for immediate next treatment visit or within 12 weeks from last patient-attended clinic visit. Visiting the clinic for a treatment more than 12 weeks from advised scheduled treatment visit renders the patient lost to follow-up.
	2.	Colon and Colon Rectum Cancer	Patient has not come back as advised for immediate next treatment visit or within 12 weeks from last patient-attended clinic visit. Visiting the clinic for a treatment more than 12 weeks from advised scheduled treatment visit renders the patient lost to follow-up.
	3.	Expanded ZMORPH	Patient has not comeback 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
	4.	Children with Developmental Disability	The patient has not come back as advised for immediate next rehabilitation visit or within four (4) weeks from last patient-attended clinic visit.  Failure to visit the clinic for a treatment more than four (4) weeks from advised scheduled rehabilitation visit
	5.	Children with Mobility Impairment	The patient has not come back as advised for the final fitting of the device, for the training on the safe and functional use of the device, or for the immediate next rehabilitation visit.  Visit the clinic for more than two weeks from advised scheduled visit



Z Benefit Package

Z Benefit Package	Lost-to-follow up	
6. Children with Visual Impairment	The patient has not come back as advised for immediate next rehabilitation visit or within four (4) weeks from last patient-attended clinic visit.	
	Visiting the clinic for a treatment more than four (4) weeks from advised scheduled rehabilitation visit	
7. Children with Hearing Impairment	a. For audiological follow-up, this means that the patient has n come back for follow-up within two months from the schedul appointment;	
	b. For speech therapy, this means that the patient has not come back for follow-up within one month from the scheduled appointment.	



