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UNIVERSAL HEALTH CARE

PHILHEALTH CIRCULAR
No. 2014 - 00 12

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.

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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 PhilHealth 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;

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 Pre-authorization 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 pre-authorization, 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 pre-authorization 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 pre-authorization request shall apply for the whole calendar year.

   Example 3: Children with disabilities. The membership category upon approval of the pre-authorization 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.

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 pre-authorization *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, p*hotocopy 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.

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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;

   c. 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 "I") for the initial policy review of the Z Benefits has been established. Improvements to the methodology of the policy review shall be made as necessary based on *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, *healthcare* professionals, healthcare *providers*, and other stakeholders, marketing and promotional activities shall be undertaken *following* the integrated marketing and communication plan of PhilHealth.

J. 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 "J":	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 "Q":	*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)."

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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.

ATTY. DANTE A. GIERRAN, CPA
President and Chief Executive Officer

Date Signed: 11/24/2021

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "A–ZMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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

PRE-AUTHORIZATION CHECKLIST FOR ZMORPH
FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

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

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

QUALIFICATIONS	
1. Age	☐ ≥*18* years
2. Status of post-amputation	☐ at least three months post-amputation, if acquired
3. Wheelchair independent, community-ambulator *(Any of the following)*	☐ with or without crutches ☐ cane or walker
4. *Absence of the following* on physical examination	☐ fresh or non-healing wound ☐ neuroma or painful residual limb
5. Tick involved limb	☐ right limb ☐ left limb ☐ both limb

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

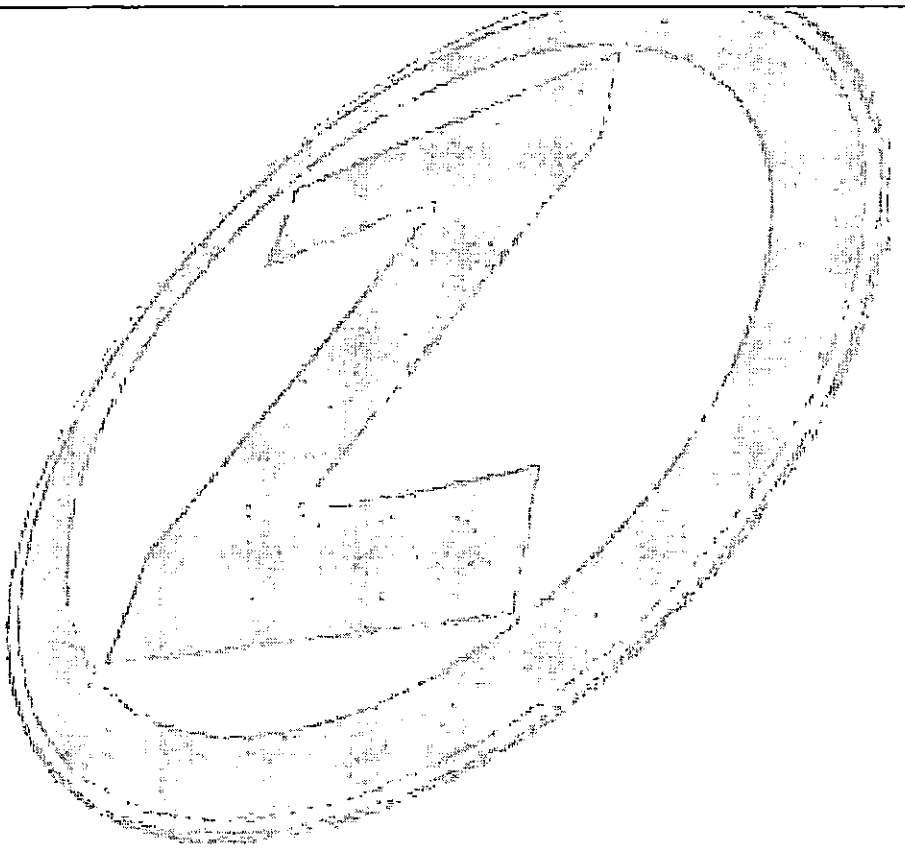
Attested by Attending Rehabilitation Medicine Specialist

_____
Printed name and signature

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

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

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



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UNIVERSAL HEALTH CARE

PRE-AUTHORIZATION REQUEST FOR ZMORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HCI*)

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

(Printed name and signature)
Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY DC: MJS Date: 12/2/2021

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A – ALL"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

MASTER COPY Date: 12/2/2021
DC: MJS

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

PRE-AUTHORIZATION CHECKLIST
Acute Lymphocytic/Lymphoblastic Leukemia
Standard Risk

Place a check mark (✓)

QUALIFICATION	YES
Age 1 to 10 years and 364 days	

Conforme by Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING PHYSICIAN

Place a check mark (✓)

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

* L3 morphology is excluded

Place a check mark (✓)

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

Certified correct by Attending Physician:

Printed name and signature

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

Note:
Once approved, the contracted *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.

MASTER COPY
DC: MJS Date: 12/2/2021

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

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

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

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

Conforme by:

(Printed name and signature)
Parent/Guardian

MASTER COPY Date: 12/2/2021 DC: MJS

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HCP*:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS
☐ APPROVED
☐ DISAPPROVED (State reason/s)

_____
(Printed name and signature)
Head or authorized BAS representative

Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HCP*:		

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex A – "Breast CA"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

MASTER COPY DC: 1145 Date: 12/7/2022

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

PRE-AUTHORIZATION CHECKLIST
Early Breast Cancer

Place a check mark (✓)

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

Place a (✓) if YES

CLINICAL STAGE (Choose only one except when breast cancer is bilateral) (Early breast cancer definitions. Source: *AJCC-NCCN v1.2022)*	Right	Left	Both
cStage 0: Tis (*ductal* carcinoma-in-situ) N0 M0			
cStage IA: T1 (tumor ≤20mm) N0 M0			
cStage IB: T0 N1mi M0; T1 (tumor ≤20mm) N1mi M0			
cStage IIA: T0 N1 M0; T1 N1 M0; T2 (tumor >20mm but ≤50mm) N0 M0			
cStage IIB: T2 N1 M0; T3 (tumor >50mm) N0 M0			
cStage IIIA: *T0 N2 M0; T1 N2 M0; T2 N2 M0; T3 N1 M0; T3 N2 M0*			

Certified correct by Attending Medical Oncologist:

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

Certified correct by Attending Surgeon:

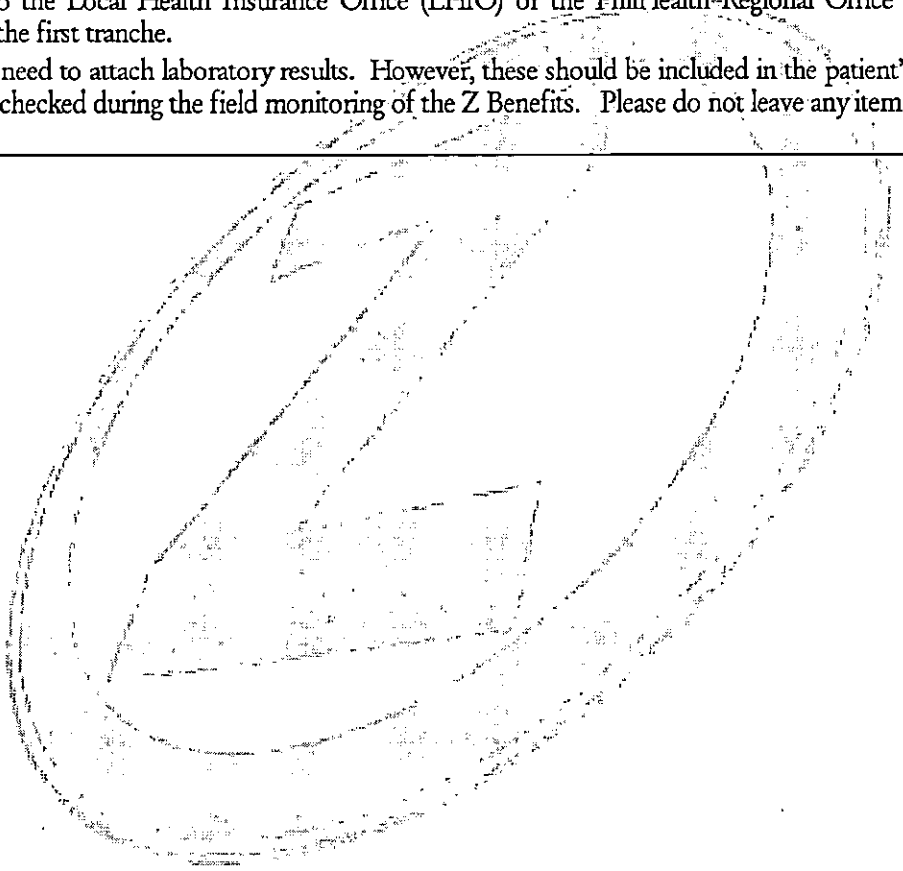
_____
Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐-☐☐☐☐☐☐-☐

Conforme by Patient:

_____
Printed name and signature

Note:
Once approved, the contracted *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.



MASTER COPY
DC: 145 Date: 12/2/2021

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PALINGA PARA SA LAHAT

PRE-AUTHORIZATION REQUEST
Early Breast Cancer

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ 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 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:	Certified correct by:
(Printed name and signature) Attending Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.

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

MASTER COPY Date: 12/2/2021
DC: mjf

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HCP*:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS
☐ APPROVED
☐ DISAPPROVED (State reason/s)

_____
(Printed name and signature)
Head or authorized BAS representative

Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HCP*:		

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGINGA PARA SA LAHAT

Case No. _____

Annex "A – 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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

MASTER COPY Date: 12/2/2021 DC: MJS

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

Place a check mark (✓)

QUALIFICATIONS	YES
At least 19 years of age	

ATTESTED BY ATTENDING CARDIOLOGIST or CARDIOVASCULAR SURGEON

Place a check mark (✓)

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

Place a check mark (✓)

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

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

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

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

MASTER COPY DC: 145 Date: 12/2/2021

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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UNIVERSAL HEALTH CARE
KALUSUGAN AT KABUHAYAN PARA SA LAHAT

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

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

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

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

MASTER COPY Date: 12/2/2021
DC: mgs

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

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

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s) _____ *(Printed name and signature)* *Head or authorized BAS representative*		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HCP*:		

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A – Cervical CA"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*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, 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 _____

MASTER COPY
DC: ____ Date: 12/3/2021

PRE-AUTHORIZATION CHECKLIST
Cervical Cancer

Place a check mark (✓)

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

Place a check mark (✓)

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

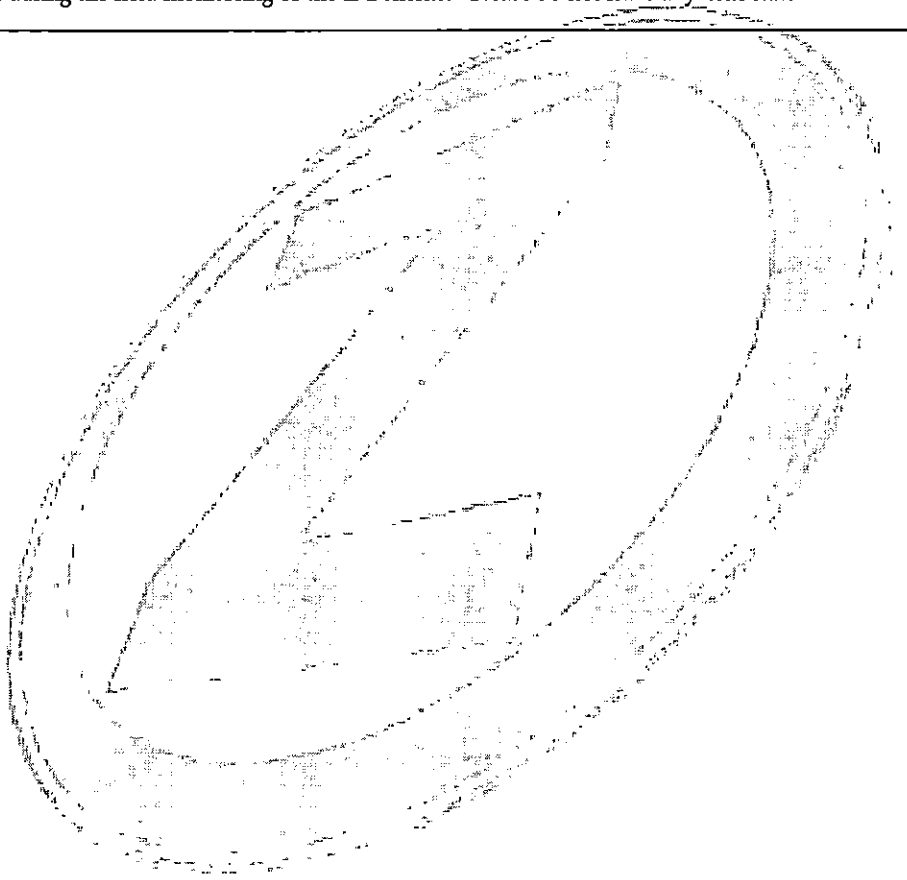
Certified correct by Attending Gynecologic-Oncologist:

_____
Printed name and signature

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

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.



MASTER COPY
Date: 12/2/2021
DC:

Republic of the Philippines

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

PRE-AUTHORIZATION REQUEST
Cervical Cancer

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

_____ in _____

(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 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:* _____

Treatment modality: (tick appropriate box)

☐ chemoradiation: chemotherapy, cobalt and brachytherapy (low dose) or primary surgery for stage IA1, IA2-IIA1

☐ chemoradiation: chemotherapy, linear accelerator and brachytherapy (low/high dose)

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

Conforme by:

(Printed name and signature)
Patient

MASTER COPY DC: mjs Date: 12/2/2021

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☐ APPROVED

☐ DISAPPROVED (State reason/s) _____

_____

(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HCP*:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS

☐ APPROVED
☐ DISAPPROVED (State reason/s)

_____
(Printed name and signature)
Head or authorized BAS representative

Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HCP*:		

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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE

Case No. _____

Annex "A1 –EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

PRE-AUTHORIZATION CHECKLIST FOR EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

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

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

MASTER COPY Date: 12/2/2021 DC: MJS

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

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

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

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

_____
Printed name and signature

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

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

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

MASTER COPY
DC: ____ Date: 12/3/2021

Republic of the Philippines

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www.philhealth.gov.ph

UNIVERSAL HEALTH CARE

PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HCI*)
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:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/ Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

(Printed name and signature)
Patient/Parent/Guardian

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY Date: 12/3/2021 DC: MJS

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

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UNIVERSAL HEALTH CARE
PAIUSUDAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A2 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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

PRE-AUTHORIZATION CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Orthosis

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

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

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

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

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

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

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

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

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

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

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

Printed name and signature

PhilHealth Accreditation No. [ ][ ][ ][ ] - [ ][ ][ ][ ][ ][ ][ ] - [ ]

MASTER COPY Date: 12/2/2021 DC: MJS

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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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

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

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HCI*)
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:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)
Patient/Parent/Guardian

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DC: MJS

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

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

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UNIVERSAL HEALTH CARE
PAGPUPUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A3 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

PRE-AUTHORIZATION CHECKLIST FOR EXPANDED ZMORPH
Spinal Orthosis

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

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

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

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

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

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

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

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

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

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

Conforme by Patient/Parent/Guardian:

Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

Printed name and signature

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

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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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UNIVERSAL HEALTH CARE

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

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HCI*)
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:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)
Patient/Parent/Guardian

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A – KT"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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

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

ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURGEON

(Place ✓ if YES or NA if not applicable)

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" under 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. Conformed by: _____ Printed name and signature ☐ patient ☐ parent ☐ guardian	

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(Place ✓ if YES or NA if not applicable)

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^2	☐ Yes ☐ NA
2. For pre-emptive kidney transplant and non-diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 15 mL/min /1.73m^2	☐ Yes ☐ NA
3. Low risk: a. Primary kidney transplant (no previous solid organ transplant)	☐ Yes
b. Single organ transplant	☐ Yes
c. Negative tissue crossmatch	☐ Yes
d. Historical Panel Reactive Antibody (PRA) Class 1 &2 negative	☐ Yes ☐ No. If "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

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Date: 12/2/2021
DC: MJS

Certified Correct by Attending Nephrologist or Transplant Surgeon:

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)

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 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:* _____

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

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DC: mys

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

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

COMPLIANCE TO REQUIREMENTS

☐ APPROVED
☐ DISAPPROVED (State reason/s)

_____
(Printed name and signature)
Head or authorized BAS representative

Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HCP*:		

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex A – "Prostate CA"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

MASTER COPY Date: 12/2/2021
DC: MJS

PRE-AUTHORIZATION CHECKLIST
Prostate Cancer

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

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES)

QUALIFICATIONS	YES
No previous radiotherapy for prostate cancer	
No uncontrolled co-morbid conditions	

(Place a ✓if YES)

DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
(T1a-T3c), Tumor Grade (Gleason's score of 6-9)		
No evidence of metastasis (documented by any of the following): ☐ Bone scan ☐ Pelvic CT/MRI ☐ PET Scan (Attach results to the patient's chart)		

Conforme by Patient/Guardian:

_____
Printed name and signature

Certified correct by Attending Physician:

_____
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 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.

MASTER COPY
DC: Date: 12/2/2021

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGKAKAISA PARA SA LAHAT

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

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

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY DC: MJS Date: 12/3/2021

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s) _____ *(Printed name and signature)* *Head or authorized BAS representative*		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ 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.			☐ Approved ☐ Disapproved		
			Released to *HCP*:		

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "A – TOF"

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	☐ *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
Tetralogy of Fallot Surgery

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

MASTER COPY Date: 12/2/2021 DC: MJS

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

QUALIFICATIONS	YES
1. Check past history: a. No previous cardiac surgery or intervention such as BTS (Blalock Taussig Shunt) b. No PDA Stenting or c. No residual VSD from previous open heart surgery for total correction	
2. Check physical examination: No hepatomegaly or No edema lower extremities	
3. No congenital chromosomal abnormalities or other congenital defects, except Trisomy 21 (Down's syndrome)	

Place a check mark (✓)

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

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

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

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

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

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

Note:
Once approved, the contracted *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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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

PRE-AUTHORIZATION REQUEST
Tetralogy of Fallot Surgery

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for

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

Conforme by:

(Printed name and signature)
Patient

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

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

COMPLIANCE TO REQUIREMENTS

☐ APPROVED
☐ DISAPPROVED (State reason/s)

_____
(Printed name and signature)
Head or authorized BAS representative

Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HCP*:		

MASTER COPY Date: 12/2/2021
DC: 1145

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A1 – VSD"

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	☐ *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 _____

MASTER COPY DC: 145 Date: 12/2/2021

PRE-AUTHORIZATION CHECKLIST
Ventricular Septal Defect (VSD) Closure

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yy)
Based on 2D Echocardiogram:[2] a. Confirmed ventricular septal defect perimembranous, subaortic or subpulmonic, or inlet type		
b. **NO** combined shunts such as atrial septal defect or atrioventricular septal defect, *Aortopulmonary window*		
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		

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

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Note:
Once approved, the contracted *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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DC: mgs Date: 12/2/2021

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KASIGURAHAN PARA SA LAHAT

PRE-AUTHORIZATION REQUEST
Ventricular Septal Defect (VSD) Closure

DATE OF REQUEST (mm/dd/yyyy)

This is to request approval for provision of services under the Z benefit package for

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

MASTER COPY DC: 143 Date: 12/2/2021

Conforme by:

(Printed name and signature)
Patient

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s) _____ *(Printed name and signature)* *Head or authorized BAS representative*		
Received by LHIO/BAS:					
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 eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HCP*:		

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PANANGGA PARA SA LAHAT

Case No. _____

Annex "A2 – VSD"

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	☐ *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
_____

MASTER COPY Date: 12/2/2021 DC: mjs

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

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yyyy)
1.Based on 2D Echocardiogram:[2] a. Confirmed ventricular septal defect perimembranous, subaortic, subpulmonic, *or inlet type*		
b. **NO** combined shunts such as atrial septal defect or atrioventricular septal defect; *Aorto-pulmonary window*		
c. **NO** LV Outflow tract obstruction (CHD): such as coarctation of the aorta		
2. Any of the following may be allowed:		
• *Associated patent ductus arteriosus*		
• *Moderate* aortic insufficiency *not warranting replacement*		
• Pulmonary or *Artery Pressure > 2/3 of systemic pressure* with reactive pulmonary bed by *ECHO documented by_* cardiac catheterization		
• *Down's Syndrome*		

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

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	☐ *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 ☐☐-☐☐☐☐☐☐☐☐-☐	

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

Note:
Once approved, the contracted 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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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

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

DATE OF REQUEST (mm/dd/yyyy)

This is to request approval for provision of services under the Z benefit package for

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

(Printed name and signature)
Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY Date: 12/2/2021 DC: 1495

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
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 one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HCP*:		

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UNIVERSAL HEALTH CARE

Numero ng kaso: _____
Case No.

Annex "B-ME Form"

MEMBER EMPOWERMENT FORM

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

Mga Panuto:
Instructions:

1. Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
   The health care provider shall explain and assist the patient in filling-up the ME form.
2. Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
   Legibly print all information provided.
3. Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka (✓) ang angkop na kahon.
   For items requiring a "yes" or "no" response, tick appropriately with a check mark (✓).
4. Gumamit ng karagdagang papel kung kinakailangan. Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
   Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
   The ME form shall be reproduced by the contracted health care institution (HCI) providing specialized care.
6. 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.

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

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

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

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

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

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

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

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

Kategorya bilang Miyembro:
Membership Category:

Direct contributor
Direct contributor

- ☐ Empleado ng pribadong sector
  Employed private
- ☐ Empleado ng gobyerno
  Employed government
- ☐ May sariling pinagkakakitaan
  Self earning
  - ☐ Indibidwal
    Individual
  - ☐ Sole proprietor
    Sole proprietor
  - ☐ Group enrollment scheme
    Group enrollment scheme
- ☐ Kasambahay / *Household Help*
- ☐ Tagamaneho ng Pamilya/ *Family driver*
- ☐ Filipinong Manggagawa sa ibang bansa
  Migrant Worker/OFW
  - ☐ Land-based *Land-based*
  - ☐ Sea-based *Sea-based*
- ☐ Habambuhay na kaanib/ *Lifetime Member*
- ☐ Filipino na may dalawang pagkamamamayan/Nakatira sa ibang bansa
  Filipino with Dual Citizenship/Living abroad
- ☐ Foreign national/*Foreign national*

Indirect contributor
Indirect contributor

- ☐ Listahanan
  Listahanan
- ☐ 4Ps/MCCT
  4Ps/MCCT
- ☐ Nakatatandang mamamayan
  Senior Citizen (RA 10645)
- ☐ PAMANA
  PAMANA
- ☐ KIA/KIPO
  KIA/KIPO
- ☐ Bangsamoro/Normalization
- ☐ Inisponsuran ng LGU
  LGU-sponsored
- ☐ Inisponsuran ng NGA
  NGA-*sponsored*
- ☐ Inisponsuran ng pribadong sector
  Private-sponsored
- ☐ Taong may kapansanan
  Person with disability

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

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

MASTER COPY Date: 12/2/2021

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

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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 pagkalabas ng pagamutan) *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 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.*		
Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang ***The following are applicable to formal and informal economy and their qualified dependents*** g. 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.* h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* 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 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 the duration of my treatment/ intervention under the Z Benefits.*		

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E. Tungkulin at Responsabilidad ng Miyembro ***E. Member Roles and Responsibilities***		
Lagyan ng (√) ang angkop na sagot o NA kung hindi nauukol *Put a (√) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. *I understand that I am responsible for adhering to my treatment schedule.*		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang Z benefits. *I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.*		
3. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong Z benefit package. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng Z benefits. *I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.*		

F. Pangalan, Lagda, Thumb Print at Petsa ***F. Printed Name, Signature, Thumb Print and Date***		
Pangalan at Lagda ng pasyente:* *Printed name and signature of patient** *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb Print (kung hindi makakasulat ang pasyente) *(if patient is unable to write)*	Petsa (buwan/ araw/ taon)
Pangalan at lagda ng nangangalagang Doktor: *Printed name and signature of Attending Doctor*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Mga Saksi: *Witnesses:*		
Pangalan at lagda ng kinatawan ng ospital: *Printed name and signature of HCI staff member*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan *Printed name and signature of spouse/ parent/ next of kin / authorized guardian or representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

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

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

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

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

I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.

Buong pangalan at lagda ng pasyente* *Printed name and signature of patient** * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. ** For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

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

☐ asawa *spouse*	☐ magulang *parent*	☐ anak *child*	☐ kapatid *next of kin*	☐tagapag-alaga *guardian*	☐ walang kasama *no companion*

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "C1 – ALL"

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

Tranche 1

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF INDUCTION PHASE (mm/dd/yyyy)		

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

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
A. **Diagnostics**	
☐ Bone marrow aspirate examination (morphologic assessment of BMA smears)	
☐ CSF analysis with WBC differential count	
☐ CBC (with platelet count)	
☐ Alanine aminotransferase (ALT)	
☐ Bilirubin	
☐ Creatinine	
☐ PT/PTT	
Electrolytes	
☐ Sodium	☐ Calcium
☐ Potassium	☐ Chloride
	☐ Magnesium
	☐ Phosphorous/*Phosphate*

Place a (✓) 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	
Chemotherapy:	
☐ Systemic	
☐ prednisone *or dexamethasone* ☐ vincristine	
☐ L-asparaginase	☐ doxorubicin
☐ Intrathecal	
☐ Single (methotrexate) OR	
☐ Triple (methotrexate, cytarabine, hydrocortisone)	
	Other drugs:
	☐ diphenhydramine
	☐ hydrocortisone
	Anti-emetics:
	☐ ondansetron
	☐ metoclopramide
	Pain medications:
	☐ nalbuphine
	☐ tramadol

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

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
	Anesthetics:
	☐ ketamine
	☐ propofol
	Sedatives (prior to procedure):
	☐ midazolam
	☐ diphenhydramine
	Antimicrobials:
	☐ cotrimoxazole
	☐ ceftriaxone
	☐ ceftazidime
	☐ amikacin
	☐ antifungal (oral) specify,
	☐ other *antimicrobials* based on hospital antibiogram specify,

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

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KALUSUGAN AT KALINGA PARA SA LAHAT

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 Name, Suffix	*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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF INTENSIFICATION OR RE-INDUCTION PHASE (mm/dd/yyyy)		

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

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
A. **Diagnostics**	
☐ CSF Analysis WBC differential count	☐ Bone marrow aspirate examination
☐ CBC with platelet count	☐ Alanine aminotransferase (ALT)
☐ Creatinine	☐ PT/PTT
☐ Bilirubin	
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)	

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

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
	Other drugs
	☐ MESNA
	☐ hydrocortisone
	Anti-emetics
	☐ ondansetron
	☐ metoclopramide
	Antimicrobials
	☐ cotrimoxazole
	☐ ceftriaxone
	☐ ceftazidime
	☐ amikacin
	☐ *antifungal (oral), specify*
	☐ Other *antimicrobials* based on hospital antibiogram Specify: _____
	☐ Blood products

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

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UNIVERSAL HEALTH CARE

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*		
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 dependent)* 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF 6th MAINTENANCE CYCLE (mm/dd/yyyy)		

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

MANDATORY SERVICES	OTHER SERVICES (As needed/ as indicated)
A. Diagnostics	
☐ CSF Analysis WBC differential count	☐ Chest X-ray
☐ CBC with platelet count	☐ Bone marrow aspirate examination
	☐ Alanine aminotransferase (ALT)
	☐ Creatinine
	☐ Bilirubin
	☐ Amylase
	☐ Cranial CT scan
	☐ CSF cytospin
	☐ Minimal residual disease by flow cytometry

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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, cytarabine, hydrocortisone)	
	Anti-emetics
	☐ ondansetron
	☐ metoclopramide
	Antimicrobials
	☐ cotrimoxazole
	☐ ceftriaxone
	☐ ceftazidime
	☐ amikacin
	☐ *antifungal (oral), specify*
	☐ Other antibiotics based on hospital antibiogram Specify: _____ _____
	☐ Blood products

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

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 *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 dependent)* 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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Place a (✓) in the appropriate tick box.

MANDATORY SERVICE	Status
A. Procedure: *(any one of the following):* ☐ *Modified radical mastectomy* ☐ *Total mastectomy with sentinel lymph node biopsy* ☐ *Partial mastectomy of the breast/ lumpectomy with axillary lymph node dissection* ☐ *Partial mastectomy/ lumpectomy of the breast with sentinel lymph node biopsy*	*Check laterality:* ☐ R breast ☐ L breast ☐ bilateral breast

MANDATORY SERVICES	OTHER SERVICES as needed/as indicated
B. Diagnostics:	
☐ Mammography for all *female 40 years old and above* ***For female, less than 40 years old (any of the following):*** ☐ *Mammography* ☐ *Ultrasound of breast and axillary bed* ***For male patients*** ☐ *Ultrasound of both breasts and axillary bed*	
☐ Histopathology	
☐ ER/HER*	

MANDATORY SERVICES	OTHER SERVICES as needed/as indicated
	☐ CBC with platelet count*
	☐ Chest X-ray PA *and lateral views**
	☐ Alkaline phosphatase*
	☐ Ultrasound of whole abdomen*
	☐ ECG
	☐ Creatinine
	☐ PT/PTT
	☐ CP clearance
	☐ FBS
	Electrolytes*
	☐ Sodium
	☐ Potassium
	☐ Chloride
	☐ Calcium
	☐ Phosphate
	☐ Urinalysis*
	☐ 2D echo**
	☐ SGPT*
	☐ SGOT*
	☐ Complete list of medicines given: (may attach a separate sheet)

*not required for cStage 0 DCIS
**not required for HER negative breast cancer

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

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

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "C2– Breast CA"

CHECKLIST OF MANDATORY AND OTHER SERVICES
Early Breast Cancer
Upon completion of one (1) month hormonotherapy or last cycle of chemotherapy for stages I-IIIA and upon completion of surgery for stage 0-*IA not requiring chemotherapy*

Tranche 2

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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Place a (✓) in the appropriate tick box.

MANDATORY SERVICES	OTHER SERVICES as indicated/as needed
A. Histopathologic Stage (Indicate): _____	
B. Complete list of medicines given:	
Hormonotherapy (for ER+ BrCa): ☐ Tamoxifen# x 5 years	☐ *letrozole x 5 years*
Chemotherapy* (any one of the following treatment protocols): ☐ Adjuvant therapy ☐ Neo-adjuvant therapy**	
☐ AC x 6 cycles doxorubicin /epirubicin*** for patients with cardiac dysfunctions, cyclophosphamide	
☐ CMF*** x 6 cycles 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	
☐ TCy x 4 cycles docetaxel, cyclophosphamide	
	☐ Biologic *therapy: trastuzumab*## *x 18 cycles*
	☐ Anti-emetic, *specify*
	☐ *Antimicrobials, specify*
	☐ Pain relievers, *specify*
	☐ Other medicines, *specify*

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

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

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KALUSUGAN AT KATINUGA PARA SA LAHAT

Case No. _____

Annex "C1 – 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	☐ *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 MANDATORY and OTHER SERVICES
Standard Risk Elective Coronary Artery Bypass Graft Surgery (CABG) – 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 :	
☐ CBC	
☐ Platelet count	
☐ Blood typing	
☐ Na	
☐ K	
☐ Mg	
☐ Calcium	
☐ FBS	
☐ BUN	
☐ Creatinine	
☐ Chest X-ray (PA/lateral)	
☐ 12-lead ECG	
☐ 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

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Place a (✓) 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.

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

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	☐ *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	☐☐ - ☐☐☐☐☐☐☐☐ - ☐

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

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

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "C1.1 – Cervical CA"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative Laboratory:	
☐ CBC	☐ Partial thromboplastin time
☐ Platelet count	☐ CT scan or MRI
☐ Blood typing	☐ Blood support (screening, processing)
☐ Chest X-ray	☐ Cystoscopy
☐ ECG	
☐ FBS	
☐ Na, K, Cl, Ca	
☐ Creatinine	
☐ AST/ALT	
☐ Pro-time	
☐ Urinalysis	
☐ Histopathology	
☐ TV-UTZ	
☐ Preoperative antibiotic prophylaxis	
	☐ Procedure done Date of procedure: (mm/dd/yyyy)_____ **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

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MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
	(Tick appropriate box; choose one) ☐ bilateral salpingoophorectomy ☐ transposition of ovaries
	☐ Blood transfusion support
	Postoperative laboratory
	☐ CBC with platelet
	☐ ECG
	☐ Electrolytes
	Postoperative medications
	☐ Analgesics
	☐ Antibiotics
	☐ Hematinics

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

Conforme by:
(Printed name and signature) Patient

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DC: nqs Date: 12/2/2021

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PANIMBA PARA SA LAHAT

Case No. _____

Annex "C1.2 – Cervical CA"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative Laboratory:	
☐ CBC	☐ Partial thromboplastin time
☐ Platelet count	☐ CT scan or MRI
☐ Blood typing	☐ Blood support (screening, processing)
☐ Chest X-ray	☐ Cystoscopy
☐ ECG	☐ Proctosigmoidoscopy
☐ FBS	
☐ Na, K, Cl, Ca	
☐ Creatinine	
☐ AST/ALT	
☐ Pro-time	
☐ Urinalysis	
☐ Histopathology	
☐ TV-UTZ	
	☐ Blood transfusion Support
Radiation Treatment Summary ☐ Pelvic cobalt radiation	**Date of Procedure** (start mm/dd/yyyy –end mm/dd/yyyy): _____
☐ Low dose brachytherapy	**Dates of Procedure** (mm/dd/yyyy): _____ _____ _____ _____

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MANDATORY SERVICES

Chemotherapy medications (Check only one chemotherapy per cycle)

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

Chemotherapy Treatment Summary

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

OTHER SERVICES

Pre chemotherapy laboratory exams per cycle

Cycle	CBC	Creatinine	Mg	Urinalysis
I				
II				
III				
IV				
V				
VI				

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				

MASTER COPY
DC: Mys Date: 12/2/2021

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGINGA PARA SA LAHAT

Case No. _____

Annex "C1.3 – Cervical CA"

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

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative Laboratory:	
☐ CBC	☐ Partial thromboplastin time
☐ Platelet count	☐ CT scan or MRI
☐ Blood typing	☐ Blood support (screening, processing)
☐ Chest X-ray	☐ Cystoscopy
☐ ECG	☐ Proctosigmoidoscopy
☐ FBS	
☐ Na, K, Cl, Ca	
☐ Creatinine	
☐ AST/ALT	
☐ Pro-time	
☐ Urinalysis	
☐ Histopathology	
☐ TV-UTZ	
	☐ Blood Transfusion Support
Radiation Treatment Summary a. Pelvic radiation ☐ Linear Accelerator b. Brachytherapy (tick one of the following) ☐ Low dose rate ☐ High dose rate	**Date of Procedure** (start mm/dd/yyyy –end mm/dd/yyyy): _____ **Dates of Procedure** (mm/dd/yyyy): _____ _____ _____ _____

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DC: Keys Date: 12/2/2024

MANDATORY SERVICES

Chemotherapy medications (Check only one chemotherapy per cycle)

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

Chemotherapy Treatment Summary

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

OTHER SERVICES

Pre chemotherapy laboratory exams per cycle

Cycle	CBC	Creatinine	Mg	Urinalysis
I				
II				
III				
IV				
V				
VI				

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 *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C1.1 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Prosthesis
Tranche 1

Place a check (✓) mark

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

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C1.2 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Upper Limb Prosthesis
Tranche 1

Place a (✓) or NA if not applicable

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

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGTINGIN PARA SA LAHAT

Case No. _____

Annex "C1.3 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH
Lower Limb Orthosis
Tranche 1

Place a check (✓) mark

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

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

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

MASTER COPY Date: 12/2/2021
DC: MJS

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "C1.4 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

DISCHARGE CHECKLIST FOR EXPANDED ZMORPH

Spinal Orthosis

Tranche 1

Place a check (✓) mark

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

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C2 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

DISCHARGE CHECKLIST FOR EXPANDED Z MORPH
Tranche 2

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

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

Rehabilitation Sessions	Dates Performed					
Physical therapy OR						
Occupational therapy						

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

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

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "C1 – KT"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Tranche 1

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

MANDATORY SERVICES	OTHER SERVICES as needed or as indicated
☐ Cardiology clearance for recipient	☐ Cardiology clearance for donor
☐ Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates	☐ Hemodialysis or peritoneal dialysis during admission for transplantation
☐ Transplantation surgery with living or deceased donor	
☐ Immunosuppressant induction therapy, unless identical twin or zero HLA-antigen mismatch	
☐ 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	

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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 + 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 ☐ 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 ☐ 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
	☐ Graft renal biopsy

MASTER COPY Date: 12/2/2021
DC: MJS

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

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UNIVERSAL HEALTH CARE

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: BT, _____ # units Date of last BT _____

EPO, Dose _____

Past Medical/Social History:

HPN DM Asthma Renal Stone COPD # of Previous

CAD Stroke PVD Liver Disease Lupus Pregnancies

Splenectomy Others, specify _____

Previous Surgeries _____ Allergies _____

Smoking (Pack years) _____ Alcohol Intake _____

Family history HPN DM CAD Others, specify _____

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

Hematology (__/__/__)

*WBC____ * Hgb____ *Hct ____ *Platelet ____ *Bleeding Time ____ *PT ____ *PTT ____

Blood Chemistries (__/__/__)

*Creatinine _____ *BUN____ *FBS ____ * Cholesterol ____ *Trig ____

*Uric Acid ____ *ALP ____ SGOT ____ *SGPT ____ *Albumin ____ *Ca ____

*P _____ *K _____ *Na _____ *Intact PTH _____

Urine Examination (__/__/__) Defer if patient if anuric.

*Sp. Gr. ____ pH____ Protein____ Sugar____ Blood____ WBC____ RBC____

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

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

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* 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 occult blood test (__/__/__)_____

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

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

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

_____

*ECG (__/__/__) _____

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

_____

Sputum c/s (__/__/__)_____

Chest CT scan (__/__/__)_____

_____

EGD (__/__/__)_____

Colonoscopy (__/__/__)_____

Aorto-iliac duplex ultrasound of arteries and veins, when indicated (__/__/__)_____

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

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

_____

Cardiac scintigraphy (__/__/__) _____

Serology: (__/__/__)

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

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

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

*PRA Specific if PRA Screen Positive, PRA Specific/PRA Single Antigen Bead (__/__/__) _____

*Tissue Crossmatch (__/__/__) _____

*Blood Type _____ *Tissue Typing ____A_____,____B_____,____DR_____,____ No. of HLA Mismatch _____

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

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

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

_____ _____

*Cardiovascular _____ Pulmonary _____

Infectious _____ Urology/Gynecology _____

Dental _____ Others _____

MASTER COPY DC: MJS Date: 12/2/2021

* Mandatory service

Certified correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

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

Date signed: _____

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UNIVERSAL HEALTH CARE

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

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

Name (Last, First, Middle)_____

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. _____

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

_____ Tel. No. _____

Nephrologist _____ Transplant Surgeon _____

Urologist _____

PhilHealth ID No. ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

PRE-KIDNEY DONATION DATA

Name of Recipient (Last, First, MI) _____

Specific relationship to the recipient

Living Related Donor

parent sibling child first cousin nephew/niece aunt/uncle

Living Non-related Donor

State relationship _____

Past Medical and Social History

No Disease HPN DM Asthma Renal Stone

Previous Surgeries _____

Allergies _____

Smoking _____ pack- years

Alcohol Intake _____ drinks/per day x _____ years

Others, specify _____

Family history

HPN DM Renal Disease, specify _____

Others, specify _____

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* 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.

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

Hematology (___/___/___)
*WBC_____ *Hgb_____ *Hct_____ *Platelet_____ *Bleeding Time_____ *PT_____ *PTT_____

Blood Chemistries (___/___/___)
*Crea _____ BUN_____ *FBS _____ *Chole _____ *Trig _____
*SGPT _____ *K _____ *Na _____ Ca _____ P _____ *Uric Acid _____
Others _____

Urine Examination:
* (___/___/___) Sp.Gr._____ pH____ Protein___ Blood___ Sugar___ WBC____ RBC____
* (___/___/___) 24-hour urine TP _____ or Urine Protein Creatinine ratio _____
* (___/___/___) Urine culture and sensitivity _____

Serology:

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

Other tests:
Stool Exam with Occult Blood: (___/___/___) _____
* Chest X-ray (___/___/___) _____
* Whole Abdominal US (___/___/___) _____
_____
* ECG (___/___/___) _____
_____
* Nuclear GFR (___/___/___) _____ ml/min Normalized GFR _____ ml/min
Right_____ ml/min _____%, Left_____ ml/min _____%
* CT Renal Angiography (___/___/___) _____
_____
* Blood Type _____ *Tissue Typing A_____,_____ B_____,_____ DR_____,_____
No. of HLA Mismatch _____

CLEARANCES *(Indicate the dates and physicians)*
Cardiovascular (___/___/___) _____
Pulmonary (___/___/___) _____
Infectious (___/___/___) _____
Urology (___/___/___) _____
Gynecologic (___/___/___) _____
Others (___/___/___) _____
* Pre-transplant Orientation (___/___/___) * Ethics Committee, if LNRD (___/___/___)

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* Mandatory service

Certified correct by Attending Nephrologist or Transplant Surgeon:

_____
Printed name and signature
PhilHealth Accreditation No. | | | | | | | | | | | | |
Date signed: _____

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

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 Name, Suffix, Middle Name	*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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Recipient	**Dates Performed** *(Should be completed within two months after discharge)*			
CBC (4x)				
Creatinine (4x)				
FBS (4x)				
Potassium (1x)				
SGPT (1x)				
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	(Printed name and signature) Patient/Parent/Guardian
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐☐	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

MASTER COPY Date: 12/2/2024 DC: NJS

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UNIVERSAL HEALTH CARE
SALUSUGAN AT KALINGA PARA SA LAHAT

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

Date: _____

Patient's Name _____ Age _____ Sex _____

Date of KT _____

Present Medications

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

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_____
Attending Physician

_____
License No.

* 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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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGINHAWA PARA SA LAHAT

Case No. _____

Annex "C – Prostate CA"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF MANDATORY AND OTHER SERVICES
Prostate Cancer

Place a (✓) in the appropriate tick box.

MANDATORY SERVICES	OTHER SERVICES as needed/as indicated
Surgery done (any of the following):	☐ CP Clearance
☐ open radical prostatectomy	☐ Chest X-ray
☐ laparoscopic radical prostatectomy	☐ ECG
☐ Core needle biopsy or TURP specimen	☐ Abdominal ultrasound
☐ Prostate specific antigen (PSA)	☐ Bone scan
	☐ CT scan/MRI of pelvis and/or abdomen
	☐ PET Scan
	☐ Creatinine
	☐ FBS
	☐ CBC
	☐ Electrolytes
	☐ Urinalysis
	☐ Medicines, specify:

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C1 – TOF"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Tranche 1

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative laboratory ☐ CBC with platelet with blood typing ☐ Chest X-ray (AP-L) ☐ Na, K, Cl, Ca ☐ Creatinine ☐ Protime ☐ Partial thromboplastin time	
☐ Pre-operative antimicrobial prophylaxis	
☐ Procedure done Repair of Tetralogy of Fallot / *VSD with pulmonic stenosis* • VSD patch closure • With RVOT patch or with infundibulectomy *or pulmonary valvotomy*	
Intra-operative medicines Anesthetic medicines: (any of the following) ☐ sevoflorane ☐ fentanyl ☐ midazolam ☐ atropine ☐ ketamine ☐ esmeron	☐ dexamethasone ☐ calcium gluconate ☐ sodium bicarbonate ☐ potassium chloride ☐ magnesium sulfate ☐ heparin ☐ protamine sulfate

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Place a (✓) 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 ☐ dobutamine ☐ nitroglycerine ☐ epinephrine
	Blood products support ☐ Fresh whole blood (FWB) ☐ Packed red blood cells (pRBC) ☐ Fresh frozen plasma (FFP)
☐ Ventilatory support	
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) ☐ dopamine ☐ dobutamine ☐ nitroglycerine drip ☐ epinephrine	☐ calcium gluconate
	Pain reliever ☐ tramadol OR ☐ ketorolac OR ☐ other pain reliever: specify _____
	Sedative ☐ midazolam OR ☐ propofol OR ☐ fentanyl ☐ *other sedative: specify* _____
	☐ antimicrobials
	☐ H2 blocker
	☐ oral digoxin
	☐ oral diuretic
	☐ oral vasodilator
	☐ paracetamol or ibuprofen

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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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:	Certified correct by:
(Printed name and signature) *Cardiovascular* Surgeon	(Printed name and signature) *Cardiovascular* Anesthesiologist
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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

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

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "C1 – VSD"

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	☐ *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 (✓) in appropriate tick box if DONE or GIVEN:

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
Preoperative Medications, Laboratory and Ancillary procedure	
☐ CBC with platelet with blood typing ☐ Na, K, Cl, Ca ☐ Creatinine ☐ Protime ☐ Partial thromboplastin time ☐ Chest x-ray (AP-L)	*Please indicate if Additional laboratory and or ancillary procedure:* ☐ *2D ECHO CFDS if initial echo was done outside* ☐ *Others (specify):* _____
☐ Pre-operative *antimicrobial* prophylaxis	
Procedure done: VSD Patch closure Intra-operative ***Medications, Laboratory and Ancillary procedure***	
Anesthetic medicines: (any of the following) ☐ Sevoflorane ☐ Fentanyl ☐ Midazolam ☐ Atropine ☐ Ketamine ☐ Esmeron	☐ Dexamethasone ☐ Calcium Gluconate ☐ Sodium Bicarbonate ☐ Potassium Chloride ☐ Magnesium Sulfate ☐ Heparin ☐ Protamine Sulfate

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

MANDATORY SERVICES	OTHER SERVICES as needed/ as indicated
☐ Ventilatory support Inotropes: (any of the following) ☐ Dopamine ☐ Dobutamine ☐ Nitroglycerine ☐ Epinephrine	Blood products support ☐ Fresh whole blood (FWB) ☐ Packed red blood cells (pRBC) ☐ Fresh frozen plasma (FFP)
Postoperative Medications, Laboratory and Ancillary procedure	
Respiratory support ☐ *Ventilator* ☐ O2 Mask / Cannula **Laboratory *and Ancillary Procedure*** ☐ CBC with platelet ☐ Chest x-ray (portable) ☐ PT ☐ PTPA ☐ Na, K, Ca ☐ ABG ☐ *2DECHO – CFDS TTE / TEE*	☐ Others (Specify) _____
Medications **Inotropes (any of the following)** ☐ Dopamine ☐ Dobutamine ☐ Nitroglycerine Drip ☐ Epinephrine **Others Specify** _____ **Sedative** ☐ Midazolam OR ☐ Propofol OR ☐ Fentanyl ☐ *other sedative: specify:* _____	**Medications** Paralysis ☐ Rocuronium **Pain reliever** ☐ Tramadol OR ☐ Ketorolac OR ☐ other pain reliever: specify **Other Medications** ☐ Calcium Gluconate ☐ Antimicrobials ☐ H2 Blocker ☐ Oral Digoxin ☐ Oral Diuretic ☐ Oral Vasodilator ☐ Paracetamol Or Ibuprofen ☐ Others (Specify): _____
Pre-discharge Medications, Laboratory and Ancillary procedure	
☐ CBC *and Platelet Count* ☐ Chest x-ray (PAL) ☐ Transthoracic echo prior to discharge (Attach results in the patient's chart)	

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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	☐ *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	

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

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "C – ZMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

DISCHARGE CHECKLIST FOR ZMORPH
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

Place a check (✓) mark

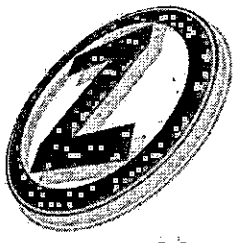
CRITERIA FOR DISCHARGE	Yes
1. External below knee lower limb prosthesis provided is as prescribed with appropriate pressure tolerant & sensitive areas, well-fitting socket, good suspension, aligned shank and stable prosthetic foot while standing and walking.	
2. The below knee stump is free of pain, 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 parameters and steps up & down five (5) steps with or without assistive device.	
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning, doffing, cleaning, precautions and falling techniques.	

MASTER COPY Date: 12/2/2021 DC: mjs

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

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

PhilHealth



Benefits

Annex "D"

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health care provider or you may contact PhilHealth call center at 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
   - ☐ Breast cancer
   - ☐ Prostate cancer
   - ☐ Kidney transplantation
   - ☐ Cervical cancer
   - ☐ Coronary artery bypass surgery
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for ventricular septal defect
   - ☐ ZMORPH/Expanded ZMORPH
   - ☐ Orthopedic implants
   - ☐ PD First Z benefits
   - ☐ Colorectal cancer
   - ☐ Prevention of preterm delivery
   - ☐ Preterm and small baby
   - ☐ Children with developmental disability
   - ☐ Children with mobility impairment
   - ☐ Children with visual disability
   - ☐ Children with hearing impairment

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2. Respondent's age is:
   - ☐ 19 years old & below
   - ☐ between 20 to 35
   - ☐ between 36 to 45
   - ☐ between 46 to 55
   - ☐ between 56 to 65
   - ☐ above 65 years old

3. Sex of respondent
   - ☐ male
   - ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the health care institution (HCI) in terms of availability of medicines or supplies needed for the treatment of your condition?
   - ☐ adequate
   - ☐ inadequate
   - ☐ don't know

5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

6. In general, how would you rate the health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
   ☐ excellent
   ☐ satisfactory
   ☐ unsatisfactory
   ☐ don't know

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

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

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

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Thank you. Your feedback is important to us!

_____
Signature of Patient/ Parent/ Guardian

Date accomplished: _____

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGIGING PARA SA LAHAT

Case No. _____

Annex "E1 – ALL"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF INDUCTION PHASE (mm/dd/yyyy)		

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

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

MASTER COPY
DC: mys Date: 2/2/2021

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E2 – ALL"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF INTENSIFICATION OR RE-INDUCTION PHASE (mm/dd/yyyy)		

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

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

MASTER COPY DC: ___ Date: 12/2/2021

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E3 – ALL"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
DATE OF END OF 6th MAINTENANCE CYCLE (mm/dd/yyyy)		

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 3)
Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)
After 6th Maintenance Cycle

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

MASTER COPY Date: 12/2/2021
DC: MJS

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E1 – Breast CA"

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	☐ *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	

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

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-Breast CA)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-Breast 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 (Annex C1-Breast CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of accomplished surgical operative report*	
8. *Photocopy of accomplished anesthesia report*	
DATE COMPLETED *(mm/dd/yyyy):*	
DATE FILED *(mm/dd/yyyy):*	

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

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

MASTER COPY
DC: mjs Date: 12/3/2021

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "E2 – Breast CA"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Upon completion of one (1) month hormonotherapy or last cycle of chemotherapy for stages I-IIIA and upon completion of surgery for stage 0-*IA not requiring chemotherapy*

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Tranche 2) (Annex E2-Breast CA)	
2. *Properly accomplished* PhilHealth Claim Form 2	
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)	

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

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

MASTER COPY DC: MJS Date: 12/2/2021

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UNIVERSAL HEALTH CARE
KALUSUGAN AT YAMANG PARA SA LAHAT

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	☐ *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) Attending Cardiologist	(Printed name and signature) Executive Director/ Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐ – ☐	PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐ – ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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

MASTER COPY
DC: MJS Date: 12/3/2021

PhilHealthofficial teamphilhealth actioncenter@philhealth.gov.ph

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Case No. _____

Annex "E2 – 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	☐ *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 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:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Executive Director/ Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐☐☐☐☐☐☐	PhilHealth Accreditation No. ☐☐☐☐☐☐☐☐☐☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Certified correct by:	Conforme by:
(Printed name and signature) Authorized Cardiac Rehabilitation Staff	(Printed name and signature) Patient
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E1.1 – Cervical CA"

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	☐ *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
Surgery for Cervical Cancer Stage IA1, IA2-IIA1

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1.1-Cervical CA)	
2. Photocopy of approved Pre –Authorization Checklist & Request (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 (Annex C1.1-Cervical CA)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of accomplished operative surgical report*	
8. *Photocopy of accomplished anesthetic report*	
9. *Original copy of* medical certificate of the out-patient follow up consultation (within 2 weeks post-op) with written request for outpatient pap smear 3 months from surgery	
10. *Photocopy of* histopathology result (definitive surgery)	

MASTER COPY DC: MJS Date: 12/2/21

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

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Case No. _____

Annex "E1.2 – Cervical CA"

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	☐ *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
Chemoradiation with Cobalt and Brachytherapy (Low Dose) for Cervical Cancer

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1.2-Cervical CA)	
2. Photocopy of approved Pre –Authorization Checklist & Request (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 (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	

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

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

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Case No. _____

Annex "E1.3 – Cervical CA"

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	☐ *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
Chemoradiation with Linear Accelerator and Brachytherapy (Low/High Dose) for Cervical Cancer

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1.3-Cervical CA)	
2. Photocopy of approved Pre –Authorization Checklist & Request (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 (Annex C1.3-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	

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

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

MASTER COPY DC: mjs Date: 12/2/21

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E1 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Expanded ZMORPH

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E1-EMORPH)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-EMORPH)	
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. Discharge Checklist for Expanded ZMORPH (Tranche 1) (Annex C1-EMORPH)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	

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

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

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DC: 1495 Date: 12/2/21

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "E2 – EMORPH"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	*(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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 2)
Expanded ZMORPH

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E2-EMORPH)	
2. Photocopy of approved Pre-Authorization Checklist & Request (Annex A-EMORPH)	
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. Discharge Checklist for Expanded ZMORPH (Tranche 2) (Annex C2-EMORPH)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	

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

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

MASTER COPY Date: 12/2/21 DC: MS

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "E1 – KT"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Requirements	**Please Check**
1. Checklist of Requirements for Reimbursement (Tranche 1) (Annex E1-KT)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-KT)	
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 (Annex C1-KT) with the following attachments: a. Pre-Transplant Evaluation Form For Kidney Transplant Recipient b. Pre-Transplant Evaluation Form For Kidney Transplant Donor	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of accomplished surgical operative report of recipient and donor	
8. Photocopy of accomplished anesthesia report of recipient and donor	

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DC: MJS

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "E2 – KT"

HEALTH CARE *PROVIDER* (*HCP*)		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	*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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGINGA PARA SA LAHAT

Case No. _____

Annex "E – Prostate CA"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Prostate Cancer

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E-Prostate CA)	
2. Photocopy of Approved Pre –Authorization Checklist & Request (Annex A-Prostate CA)	
3. Photocopy of Accomplished ME FORM (Annex B)	
4. *Properly accomplished* PhilHealth Claim Form 1 (CF1) or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
5. Checklist of Mandatory and Other Services for Prostate CA (Annex C-Prostate CA)	
6. Photocopy completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of accomplished surgical operative report	
8. *Photocopy of accomplished anesthesia report*	

MASTER COPY DC: mjs Date: 12/2/21

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

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "E1 – TOF"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OR REQUIREMENTS FOR REIMBURSEMENT (TRANCHE 1)
Tetralogy of Fallot – Elective TOF Repair

Place a check mark (✓)

Requirements	YES
1. Checklist of Requirements for Reimbursement (Annex E1-TOF)	
2. Photocopy of approved Pre –Authorization Checklist & Request (Annex A-TOF)	
3. Photocopy of completed ME FORM (Annex B)	
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-TOF)	
6. Photocopy of completed and signed Z Satisfaction Questionnaire (Annex D)	
7. *Photocopy of* accomplished surgical operative report	
8. *Photocopy of* accomplished anesthesia report	

MASTER COPY Date: 12/2/21 DC: mys

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT PAGINGA PARA SA LAHAT

Case No. _____

Annex "E2 – TOF"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Place a check mark (✓)

Requirements	YES
1. Checklist of Requirements for Reimbursement (Annex E2-TOF)	
2. *Properly accomplished PhilHealth Claim Form 2*	
3. Completed Cardiac Rehabilitation Form	
4. Medical certificate of OPD consultation	

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

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KAUNLARAN PARA SA LAHAT

Case No. _____

Annex "E1 – VSD"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

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

Place a check mark (✓)

Requirements	YES
1. Checklist of Requirements for Reimbursement (Annex E1-VSD)	
2. Photocopy of approved Pre-Authorization Checklist & Request (Annex A-VSD)	
3. Photocopy of completed ME FORM (Annex B)	
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)	
6. Photocopy of completed and signed 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) Attending *Pediatric Cardiologist*	(Printed name and signature) Executive Director/ Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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

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UNIVERSAL HEALTH CARE

Case No. _____

Annex "E2 – VSD"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Place a check mark (✓)

Requirements	YES
1. Checklist of Requirements for Reimbursement (Annex E2-VSD)	
2. *Properly accomplished PhilHealth Claim Form 2*	
3. Completed Cardiac Rehabilitation Form	
4. Medical certificate of OPD consultation	

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

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

MASTER COPY Date: 12/2/21 DC: mjs

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

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 PhilHealth.

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

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

Policy Review Guide for the Z Benefits

Health Finance Policy Sector
Product Team for Special Benefits

I. Introduction

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

II. Methodology

A. Knowledge update

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

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

B. Matrix guide for the policy review process

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

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

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

D. Building consensus with key stakeholders

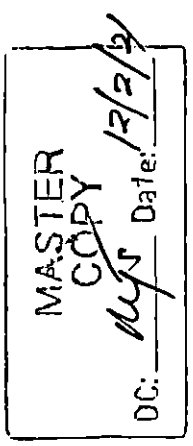
The policy review team, in collaboration with the key stakeholders, shall address the policy gaps identified and shall also consider the action plans listed in the matrix guide of the review process. Consensus building shall be conducted in order to arrive at an agreement and resolution for issues raised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

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

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

F. Disseminating the amendments and revisions in the policy

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



Annex "J"
List of Mandatory Services

Z BENEFIT FOR ACUTE LYMPHOCYTIC/LYMPHOBLASTIC LEUKEMIA, STANDARD RISK

Table 1. Services included for Induction Phase

Mandatory Services (Minimum Standards) Induction Phase	Other Services Induction Phase
A. Diagnostics 1. bone marrow aspirate examination (morphologic assessment of BMA smears) 2. CSF analysis with WBC differential count 3. CBC (with platelet count) 4. alanine aminotransferase (ALT) 5. bilirubin 6. creatinine 7. PT, PTT 8. uric acid 9. chest x-ray	**A. Other diagnostics, as indicated** 1. *calcium* 2. *chloride* 3. magnesium 4. phosphorous/ *phosphate* 5. 2D echocardiography 6. flow cytometric immunophenotyping 7. CSF cytospin 8. abdominal ultrasound 9. evaluation of infection (ex. blood culture, etc.) 10. cytogenetics
B. Electrolytes 1. Sodium 2. Potassium	**B. Blood support and processing** 1. blood typing 2. cross-matching 3. blood screening 4. blood products (i.e. packed RBC, platelet concentrate, fresh frozen plasma)
C. Chemotherapy 1. Systemic *a)* prednisone *or dexamethasone* b) vincristine c) L-asparaginase 2. Intrathecal a) single (methotrexate), OR b) triple (methotrexate, cytarabine, hydrocortisone)	**C. Other Systemic Chemotherapy,** as indicated, such as doxorubicin **D. Other drugs,** as indicated, such as diphenhydramine or hydrocortisone **E. Antiemetics,** as indicated, such as ondansetron or metoclopramide **F. Pain medications,** as indicated, such as nalbuphine, tramadol **G. Anesthetics,** as indicated, such as ketamine, propofol **H. Sedatives** prior to lab procedure, as indicated, such as midazolam, diphenhydramine ***I. Antimicrobials*** 1. cotrimoxazole

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

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

Mandatory Services (Minimum Standards) Consolidation, Interim Maintenance and Delayed Intensification Phases	Other Services Consolidation, Interim Maintenance and Delayed Intensification Phases
A. Diagnostics 1. CSF Analysis WBC differential count 2. CBC (with platelet count) 3. creatinine 4. bilirubin	**A. Other Diagnostics,** if needed 1. bone marrow aspirate examination 2. alanine aminotransferase (ALT) 3. PT/PTT
B. Chemotherapy 1. Systemic a) prednisone *or dexamethasone* b) vincristine c) cytarabine d) cyclophosphamide e) methotrexate (IV and oral) f) 6-mercaptopurine 2. Intrathecal a) single (methotrexate), OR b) triple (methotrexate, cytarabine, hydrocortisone)	**B. Chemotherapy** 1. doxorubicin 2. L-asparaginase **C. Other drugs,** as indicated 1. MESNA 2. hydrocortisone **D. Antiemetics,** as indicated 1. ondansetron 2. metoclopramide ***E. Antimicrobials*** 1. co-trimoxazole 2. ceftriaxone 3. ceftazidime 4. amikacin *5. antifungal (oral), specify* 6. Other antimicrobials based on hospital antibiogram **F. *Blood products***

Table 3. Services included for Maintenance Phase

Mandatory Services (Minimum Standards) Maintenance Phase	Other Services Maintenance Phase
A. Diagnostics 1. CSF Analysis WBC differential count 2. CBC (with platelet count)	**A. Other diagnostics** 1. chest X-ray 2. bone marrow aspirate examination 3. 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 1. Systemic a) prednisone *or dexamethasone* b) vincristine c) methotrexate (oral) d) 6-mercaptopurine 2. Intrathecal a) single (methotrexate), OR b) triple (methotrexate, cytarabine, hydrocortisone)	**B. Chemotherapy** Systemic (i.e. doxorubicin) **C. Antiemetics, as indicated** 1. ondansetron 2. metoclopramide ***D. Antimicrobials*** 1. co-trimoxazole 2. ceftriaxone 3. ceftazidime 4. amikacin *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**
B. Diagnostics 1. mammography for all female 40 years old and above 2. ultrasound of breast and axillary bed for female less than 40 years old 3. ultrasound of both breasts and axillary bed for male	**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. histopathology **D. ER/HER***	**C. other medicines**

* Not required for cStage 0 (DCIS)
** Not required for HER negative breast cancer

Table 2. Services included for Breast Cancer, Tranche 2

Mandatory Services (Minimum Standards)	Other Services
A. Diagnostics histopathological staging	
B. Adjuvant or Neo-adjuvant Therapy 1. Chemotherapy* with: a) AC x 6 cycles doxorubicin /epirubicin*** for patients with cardiac dysfunctions, cyclophosphamide OR b) CMF**** x 6 cycles cyclophosphamide, methotrexate, fluorouracil c) Docetaxel-Carboplatin (TCb) x 4 cycles For ER-HER- BrCa d) AC x 4 cycles + T x 4 cycles doxorubicin/epirubicin***, cyclophosphamide, docetaxel e) TCy x 4 cycles docetaxel, cyclophosphamide 2. Hormonotherapy with: Tamoxifen# x 5 years	**A. Other drugs, as needed,** 1. biologic therapy, trastuzumab ## x 18 cycles 2. anti-emetics 3. antimicrobials 4. pain-relievers 5. other medicines **B. Other hormonotherapy** Letrozole x 5 years **C. Radiotherapy** Not included in the Z Benefits but as a separate benefit under Case Rates

*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

##Trastuzumab for HER+ BrCa; modify chemotherapy regimen as TCH-H, AC+TH-H (doxorubicin and trastuzumab (H) cannot be given simultaneously)

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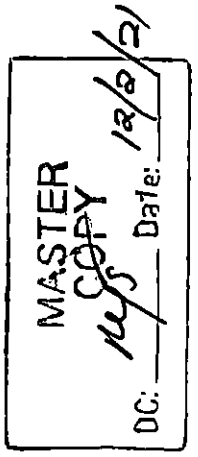
Z BENEFIT FOR PROSTATE CANCER, LOW TO INTERMEDIATE RISK

Mandatory Services (Minimum Standards)	Other Services
A. Surgery 1. laparoscopic radical prostatectomy OR 2. open radical prostatectomy **B. Core needle biopsy or TURP specimen** **C. Prostate Specific Antigen (PSA)**	**A. CP Clearance** **B. Other diagnostic tests, if needed:** 1. chest X-ray 2. ECG 3. abdominal ultrasound 4. bone scan 5. CT scan / MRI of pelvis and abdomen 6. PET scan **C. Other labs, if needed:** 1. creatinine 2. FBS 3. CBC 4. electrolytes 5. urinalysis **D. Other drugs, as needed**



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	B. Hemodialysis or peritoneal dialysis during admission for transplantation, if indicated
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 (Minimum Standards)	Other Services
Phase 1 CBC blood typing PT/PTT bleeding Time FBS creatinine urinalysis HBsAg, anti-HBs, anti-HBc CMV IgG anti-HCV HIV TPPA chest x-ray ultrasound of the whole abdomen Phase 2 PRA screen PRA specific Phase 3 tissue cross-match with living donor HLA tissue typing	Phase 1 HBV-DNA if only anti-HBc+ Chest CT scan

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

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

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

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

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

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

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

Table 6. Laboratory Monitoring for Recipient and Donor

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

Z BENEFIT FOR CORONARY ARTERY BYPASS GRAFT SURGERY

Table 1. Services included for coronary artery bypass graft surgery

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

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Z BENEFIT FOR TETRALOGY OF FALLOT

Table 1. Services included for Tetralogy of Fallot

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

Z BENEFIT FOR VENTRICULAR SEPTAL DEFECT

Table 1. Services included for Surgery of Ventricular Septal Defect

Mandatory Services (Minimum Standards)	Other Services
A. 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	**A. Pre-operative medication, laboratory and ancillary procedure** 2D echo CFDS
B. Procedure done: VSD patch closure	
C. 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 e) Na, K, Ca f) ABG g) *2D ECHO-CFDS* TTE/*TEE* 3. Medications a) Any of the following inotropes: 1) dopamine	**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 5. H2 blocker 6. oral digoxin 7. oral diuretic 8. oral vasodilator 9. paracetamol or ibuprofen

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

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Z BENEFIT FOR CERVICAL CANCER STAGE IA1, IA2-IIA1

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

Mandatory Services (Minimum Standards)	Other Services
A. Preoperative laboratory 1. CBC 2. platelet count 3. blood typing 4. chest x-ray 5. ECG 6. FBS 7. Na, K, Cl, Ca 8. creatinine 9. AST/ALT 10. pro-time 11. urinalysis 12. histopathology 13. imaging: TV-UTZ	**A. Surgery (if indicated)** **For Stage IA1 alone:** Extrafascial/Total Hysterectomy with or without bilateral salpingoophorectomy **For stage 1A2 -1B1:** Radical Hysterectomy with bilateral pelvic lymphadenectomy, paraortic lymph node sampling: Bilateral salpingoophorectomy OR Transposition of ovaries **B. Blood transfusion support**
B. Preoperative antibiotic prophylaxis	**C. Other preoperative laboratory** 1. Partial thromboplastin time 2. CT scan or MRI 3. Blood support (screening, processing) 4. Cytoscopy
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 Standards)	Other Services
Radiation Treatment Summary • pelvic radiation (pelvic cobalt) • brachytherapy (low dose)	**Blood Transfusion Support (if indicated)**
Preoperative laboratory a. CBC b. platelet count c. blood typing d. chest x-ray e. ECG f. FBS g. Na, K, Cl, Ca h. creatinine i. AST/ALT j. pro-time k. urinalysis l. histopathology m. imaging: TV-UTZ	**Preoperative laboratory (if indicated)** a. partial thromboplastin time b. imaging: CT scan or MRI c. blood support (screening, processing) d. cystoscopy e. proctosigmoidoscopy **Postoperative Laboratory (if indicated)** a. CBC with platelet b. ECG c. electrolytes
Chemotherapy medications a. cisplatin b. carboplatin	**Pre-chemotherapy laboratory exams (if indicated)** a. CBC b. creatinine c. magnesium d. urinalysis
Follow up consultation (within 2 weeks post-procedure)	**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

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

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

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

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

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

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

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

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

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

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

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

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

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

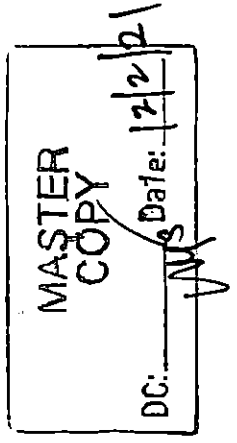

Table 5. Summary of codes for the Z benefits for coronary artery bypass graft surgery, standard risk

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

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

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

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

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

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

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

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

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

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.

II. 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.

Annex L2

- KOPYA PARA SA PHILHEALTH -

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

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

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

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

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

Pangalan _____ **Edad** _____

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

✂----------

- KOPYA PARA SA MIYEMBRO -

MASTER COPY DC: MJS Date: 12/2/21

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)** _____

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Annex L3

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

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

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

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

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

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

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

MASTER COPY Date: 12/2/21 DC: MJS

Name and signature: _____

Date signed: _____

Relationship to patient (if applicable): _____

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

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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Annex "L-ALL"

Control Number: _____

Z BENEFIT FIELD VALIDATION TOOL FOR ACUTE LYMPHOCYTIC LEUKEMIA

READ BEFORE STARTING THE INTERVIEW:

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

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

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

MASTER COPY Date: 12/2/21 DC: MJS

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

If respondent is not the patient

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

Satisfaction:

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

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

_____
_____
_____

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

_____
_____
_____

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

15. Kung *hindi*, ito ba ay
☐ desisyon ng mga magulang
☐ sinabi ng kanyang doktor
☐ may ibang nagpayo; sino? _____
(proceed to 20)

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

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

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

_____
_____
_____

PhilHealth Benefit:

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

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

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

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

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

24. Noong nag-chemotherapy ang pasyente,

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

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

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

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

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

_____

_____

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

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

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

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

30. a. **Medicines:**

Generic name	No. of units	Unit cost	Total cost

b. **Supplies:**

Item	No. of units	Unit cost	Total cost

c. **Diagnostics/ laboratory exams:**

Diagnostics/lab exams	No. of times	Unit cost	Total

d. **Professional Fees:**

Initials	Specialty	Amount

31. Ano ang gamit ninyong sasakyan papunta ng:

Ospital

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

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

☐ Lubos na nasiyahan

☐ Nasiyahan

☐ Di gaanong nasiyahan

☐ Di nasiyahan

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

_____
_____
_____
_____

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

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

Time of Interview: _____

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KALUSUGAN AT KASIGURAHAN PARA SA LAHAT

Annex "L-Surgery, Chemotherapy"

Control Number: _____

Z BENEFIT FIELD VALIDATION TOOL FOR:

READ BEFORE STARTING THE INTERVIEW:

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

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

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

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

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If respondent is not the patient

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

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

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

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

Employment status:

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

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

Satisfaction:

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

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

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

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

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

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

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

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

PhilHealth Benefit:

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

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

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

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

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

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

29. Habang kayo ay naka-admit,

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

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

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

30. Noong kayo ay nag-chemotherapy,

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

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

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

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

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

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

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

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

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

36. a. **Medicines:**

Generic name	No. of units	Unit cost	Total cost

b. **Supplies:**

Item	No. of units	Unit cost	Total cost

c. **Diagnostics/ laboratory exams:**

Diagnostics/lab exams	No. of times	Unit cost	Total

d. **Professional Fees:**

Initials	Specialty	Amount

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37. Ano ang gamit ninyong sasakyan papunta ng:

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

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

☐ Lubos na nasiyahan

☐ Nasiyahan

☐ Di gaanong nasiyahan

☐ Di nasiyahan

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

_____
_____
_____
_____

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

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

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Annex "L-Surgery"

Control Number: _____

Z BENEFIT FIELD VALIDATION TOOL FOR:

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

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

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

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

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

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If respondent is not the patient

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

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

9. **Age:** _____

10. **Sex:** ☐ male ☐ female

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

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

Employment status:

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

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

Satisfaction:

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

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

_____
_____
_____

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

_____
_____
_____

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PhilHealth Benefit:

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

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

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

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

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

23. Habang kayo ay naka-admit,

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

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

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

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

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

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

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

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

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

29. a. **Medicines:**

Generic name	No. of units	Unit cost	Total cost

b. **Supplies:**

Item	No. of units	Unit cost	Total cost

c. **Diagnostics/ laboratory exams:**

Diagnostics/lab exams	No. of times	Unit cost	Total

d. **Professional Fees:**

Initials	Specialty	Amount

30. Ano ang gamit ninyong sasakyan papunta ng:

Ospital

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

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

☐ Lubos na nasiyahan

☐ Nasiyahan

☐ Di gaanong nasiyahan

☐ Di nasiyahan

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

_____
_____
_____
_____
_____

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

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

Time of Interview:
_____

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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

* Age 0 – 18 years and 364 days for PD First Z Benefits requires written informed consent from the parents or guardian
** Mother – no age required

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Annex "O – Breast Cancer Medical Records Summary"

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	☐ *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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

BREAST CANCER MEDICAL RECORDS SUMMARY FORM

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

I. Breast Cancer Disease Profile

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

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

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

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

II. Breast Cancer Treatment Profile

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

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

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

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

III. Breast Cancer Survival Status

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

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

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Case No. _____

Annex "P – Additional Services"

LIST OF ADDITIONAL SERVICES FOR COMPLICATED CASES

HEALTH CARE *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 dependent)* 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

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

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

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

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

Other services	Indication	Hospital charge/ Amount(Php)

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

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Annex "Q"

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

Z Benefit Package	Validity Period (Calendar days)
1. 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

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
1st	300,000.00	Within 60 days after the discharge after the end of induction phase
2nd	125, 000.00	Within 60 days after the end of intensification or re-induction phase
3rd	75,000.00	Within 60 days after the 6th maintenance cycle

II. Breast Cancer

Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
1st	75,000.00	Within 60 days after discharge from surgery
2nd	25,000.00	Within 60 days upon completion of last cycle of chemotherapy for Stage I to IIIA or upon completion of surgery for Stage 0

III. Coronary Artery Bypass Graft (CABG) Surgery

Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
1st	500,000.00	Within 60 days after discharge after the surgery
2nd	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)

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IV. Cervical Cancer

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

Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
1st	125,000.00	Within 60 days after discharge from surgery for primary surgery or from the first follow up without complications (pelvic exam done) if with chemoradiation

B. Cervical Cancer chemoradiation with Linear accelerator and brachytherapy (High Dose)

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	Amount (Php)	Deadline of submission of claims
1st	550,000.00	Within 60 days upon discharge of recipient after the transplantation
2nd	50,000.00	Ninety (90) days after the transplantation

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VI. PD First Z Benefits

Number of Tranche Payment	Amount (Php)	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
1st	100,000.00	Within 60 days after discharge from surgery

VIII. Tetralogy of Fallot

Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
1st	270,000.00	Within 60 days after discharge from surgery
2nd	50,000.00	Within 60 days after completion of Rehabilitation Exercise Sessions (3rd and 4th session in the first week post - op

IX. Ventricular Septal Defect

Order of Tranche Payment	Amount (Php)	Deadline of submission of claims
1st	200,000.00	Within 60 days after discharge from surgery
2nd	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.

Z Benefit Package	Lost-to-follow up
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 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

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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 not come back for follow-up within two months from the scheduled appointment; b. For speech therapy, this means that the patient has not come back for follow-up within one month from the scheduled appointment.