PhilHealth
Your Partner in Health

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PHILHEALTH CIRCULAR
No. 2023 - 0007

TO : **ALL CONTRACTED *HEALTH FACILITIES FOR THE Z BENEFITS FOR SELECTED ORTHOPEDIC IMPLANTS*, AND ALL OTHERS CONCERNED**

SUBJECT : **Z Benefits for Selected Orthopedic Implants *(Revision 2)***

I. RATIONALE

The Philippines adopted a social health insurance system to achieve Universal Health Coverage. Thus, by virtue of Republic Act (RA) No. 7875, as amended by RA Nos. 9241 and 10606, and RA No. 11223, PhilHealth aims to cover all Filipinos and provide access to a comprehensive set of benefits without causing financial hardship. Foremost, the primary policy objective of healthcare financing is protection against the financial risk of ill health.

While PhilHealth covers hospitalization expenses for surgical procedures, the prohibitive cost of orthopedic implant devices is not entirely covered and thus becomes members' out-of-pocket expenses. The high prices of orthopedic implant devices are not affordable to most patients. Delayed surgeries are the consequence while patients or their families seek medical assistance from other sources and lead to prolonged lengths of stay in the hospital. Delays in surgery increase mortality in elderly patients by 30 percent, as well as productivity losses.

Health financing is an intervention to a lingering health system problem involving orthopedic care in the Philippines. Thus, with PhilHealth Board Resolution (PBR) No. 2750, s. 2022, PhilHealth shall cover the expenses for specialized medical devices, including orthopedic implants.

II. *OBJECTIVES*

This PhilHealth Circular aims to define the policies and procedures for implementing the Z Benefits package for selected orthopedic implants.

III. *SCOPE*

This PhilHealth Circular shall apply to all contracted health facilities (HFs) to deliver the defined mandatory services for the Z Benefits for selected orthopedic implants and other relevant stakeholders involved in its implementation.

IV. *DEFINITION OF TERMS*

A. ***Contracted Health Facility (HF)*** *– a PhilHealth-accredited health facility that enters into a contract with PhilHealth for the provision of specialized care for the Z Benefits.*

B. ***Co-payment*** *– a pre-determined amount agreed upon by the contracted healthcare provider and PhilHealth that will be charged to patients as their share for amenities or any additional or upgrade of services per cycle of care of the Z Benefits beyond the covered services. Co-payments shall have a fixed limit*

or cap not to exceed the corresponding rate of the Z Benefits package. The contracts of the health facilities shall stipulate the amount of co-payment.

C. ***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 Benefits packages. In the context of selected orthopedic implants, lost to follow up means that the patient has not come back as advised for the immediate next rehabilitation treatment visit or within two weeks from the next scheduled patient visit. As such, visiting the clinic for rehabilitation services more than two weeks from the advised scheduled treatment visit renders the patient lost to follow up.*

D. ***Member Empowerment (ME) Form*** – *a document showing that the patient is fully informed of their Z Benefits package, treatment options, treatment schedule and follow-up visits, roles, and responsibilities. The ME Form also documents that the contracted health facility provided education, counseling, and other pertinent courses of action. The beneficiary or their guardian or representative and the attending healthcare provider in charge jointly sign the ME form.*

E. ***Multiple injuries*** - *injuries that fall into more than one body region group.*

F. ***Orthopedic Implant*** – *a device designed to replace a joint, bone, or cartilage causing damage or deformity requiring orthopedic surgical procedure due to fractures resulting from vehicle-related accidents, falls, and osteoarthritis, among others.*

G. ***Pre-authorization*** – *an approval process of PhilHealth that gives the contracted HF the information that the patient fits the definition for the minimum selection criteria for the availment of the Z Benefits.*

H. ***Rehabilitation session*** - *the assessment, creation of management protocol and therapy sessions with either a physical or occupational therapist. For the Z Benefits for selected orthopedic implants, PhilHealth requires a minimum of four (4) rehabilitation sessions to be rendered to patients availing of the benefits package.*

V. *POLICY STATEMENTS*

A. Patient Assessment and Pre-authorization Process

1. *The Z Benefits shall cover the provision of selected orthopedic implants and rehabilitation sessions and those cases that strictly fulfill the selection criteria for benefit availment;*

2. *Contracted HF must screen all patients who require orthopedic implants. These patients shall be entitled to the Z Benefits package if they fit the clinical definition or selection criteria for pre-authorization.*

3. Pre-authorization from PhilHealth based on the approved selection criteria for the provision of selected orthopedic implants shall be required prior to availment of services except for *patients requiring urgent care and admission.*

   For patients requiring urgent care and admission, the contracted HF shall submit the accomplished pre-authorization checklist and request (Annexes A.1 – A.6) based on the orthopedic implants availed of and Member Empowerment Form (Annex B) within two (2) working days after surgery.

For surgeries performed on a weekend or public holiday (where submission after two working days is not feasible), the *HF* shall submit the pre-authorization checklist on the next working day after the weekend or holiday. *The said document may also be scanned and emailed to their respective PhilHealth Regional Office (PRO) for approval.*

All requests for pre-authorization shall be accomplished completely *and correctly* by the contracted *HF* and submitted to the *head or authorized representative* of the Benefits Administration Section (BAS) *of the PRO* for approval.

4. *Elective cases (i.e., non-fracture hip replacement and knee replacement) will require approved preauthorization prior to admission.*

5. The fulfillment of the selection criteria shall be the basis for *the* approval of the pre-authorization request *by PhilHealth.*

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

7. *All contracted HFs shall remind their patients to update their member profiles and premium contributions as part of their obligations.*

8. *The PhilHealth Benefit Eligibility Form (PBEF) shall be the primary proof of benefit eligibility. A PBEF with a "Yes" indication is sufficient, meaning the patient is eligible to avail of the Z Benefits. Submission of other documents, such as Member Data Record (MDR) and PhilHealth Claim Form 1 (CF1), shall no longer be required.*

9. A NO *indication on the PBEF means the member shall present MDR or duly accomplished CF1.*

10. *The contracted HF shall thoroughly discuss the co-payment with the patient during the administration of the ME form to inform them of any additional charges covering the share for amenities or any extra or upgrade of services not covered by the Z Benefits package.*

11. *The co-payment shall have a fixed limit or cap not to exceed the corresponding rate of the Z Benefits package. The contract of the HF indicates the maximum allowable amount of co-payment of the patient.*

B. *PhilHealth shall directly reimburse the entire package amount once the contracted HF has complied with all the requirements for claims submission of this Z Benefits package.*

C. *Patients admitted in basic or ward accommodation are excluded from co-payment. However, if they would opt for amenities, such as an upgrade of room accommodation or additional services not covered by PhilHealth, contracted HFs can charge a co-payment that shall not exceed the package rate. The ME Form is the documentation of the agreement on co-payment between the patient and the contracted HF.*

D. Rules on pooling professional fees for government facilities shall apply.

E. Patients enrolled in the Z Benefits shall be deducted a maximum of five (5) days from the 45 days annual benefit limit. Such deductions shall be made only *in* the current year during

the fixation of the implant. In cases where the remaining annual benefit is at least one (1) day at the time of application for pre-authorization, the member shall remain eligible to avail of the Z Benefits; no further deductions *on the 45 days annual benefit limit* will be made for the duration of the hospitalization of the patient availing the Z benefits.

F. *Contracted HFs shall regularly remind these patients to update their member profiles and premium contributions, as applicable, to ensure continuous coverage under the Z Benefits.*

G. Those who will avail of *the* Z benefits for *orthopedic implants* shall not be eligible for the same procedure *at* the same site *in* the next five (5) years; if warranted, re-admission shall be covered by the benefits on all case rates *(ACR)*.

H. *A*pplicable policies on *ACR are* reflected in separate issuances.

I. All rates are *considered* inclusive of government taxes or *net of mandatory discounts, as applicable.*

J. *PhilHealth shall establish quality standards and indicators in collaboration with the contracted reference HF, clinical experts, and other pertinent stakeholders. All contracted HFs for the Z Benefits for selected orthopedic implants shall comply with these quality standards and indicators, which shall have a bearing on the renewal of all future contracts with PhilHealth. These quality standards and indicators shall be updated, as needed, based on current evidence and standards of practice.*

K. *Orthopedic implants are* subject to regulation by the Food and Drug Administration (FDA) of the Philippines. *Therefore, the contracted reference HF shall provide PhilHealth with the list of acceptable suppliers for medical devices under the process of FDA approval. Orthopedic implant companies shall be allowed to supply devices/implants for the Z Benefits, provided they have secured Certificates of Medical Registration or Certificate of Medical Device Notification or Certificate of Medical Device Listing from FDA. Further, the reference HF shall update the list on a regular basis.*

PhilHealth shall post the list of orthopedic implants covered under the Z Benefits on the PhilHealth website.

L. *Patient for procedures involving single or multiple injuries with donated medical devices shall not be covered under the Z benefits.*

M. The medical devices shall be implanted in patients by a PhilHealth-accredited physician certified by the Philippine Board of Orthopedics and privileged to practice in the contracted *HF.*

N. All patients availing of the Z Benefits for *selected orthopedic implants* shall be monitored for all clinically relevant outcomes in the next six (6) months. *In addition, claims of contracted HFs* may be subject to post-audit by PhilHealth.

O. *Contracted HFs shall properly document patients lost to follow-up post-surgery and provide the appropriate study and analysis in the context of quality healthcare.*

P. *Mandatory or the Minimum Standards of Care, Package Rate, and Criteria for Inclusion in the Z Benefits*

The *general* package code for the Z benefits for selected orthopedic implants is **Z011.** The following are the corresponding descriptions, orthopedic implants and rates of the package:

1. Implants for hip arthroplasty

Package Code	Description	Z Package rate per side (left or right) (PHP)	Tranche 1 (PHP)	Tranche 2 (PHP)
Z011A	Total Hip Prosthesis, cemented	210,000	189,000	21,000
Z011B	Total Hip Prosthesis, cementless	260,000	234,000	26,000
Z011C	Partial Hip Prosthesis, bipolar	230,000	207,000	23,000
Z011J	*Total hip prosthesis, hybrid*	*230,000*	*207,000*	*23,000*
Z011K	*Partial hip prosthesis, unipolar modular*	*210,000*	*189,000*	*21,000*

Table 1: Package Code, Descriptions, Orthopedic Implants and Rates of the Package for Hip Arthroplasty

The use of cemented, cementless and hybrid total hip prostheses depends on the bone morphology and quality. The use of bipolar and unipolar Partial Hip Prosthesis depends on the activity-level and pre-morbid conditions of the patient.

The following are the *selection* criteria for hip arthroplasty:

a. Clinical features
   - a.1. *Hip* fracture
     - a.1.1. *With* avascular necrosis of the femoral head; OR
     - a.1.2. *Neglected* fracture of the hip; OR
     - a.1.3. *Hip* fracture with pre-existing cox-arthritis; OR
     - a.1.4. *Displaced* hip fracture
   - a.2. *With* avascular necrosis of the femoral head (FICAT Stage III and IV); OR
   - a.3. *Hip* dysplasia with subsequent osteoarthritis (CROWE I-IV); OR
   - a.4. *Severe* degenerative osteoarthritis; OR
   - a.5. *Severe* inflammatory joint disease (rheumatoid, gout, psoriatic, ankylosing spondylitis, *SLE*)

b. Pre-injury status: ambulatory patients

c. With no more than *2-3* co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   - c.1. ASA I – Normal healthy patient
   - c.2. ASA II - Patient with mild systemic disease; no functional limitation
   - c.3. ASA *III- Patient with one or more moderate to severe diseases*

2. Implants for hip fixation

Package Code	Description	Z Package rate per side (left or right) (PHP)	Tranche 1 (PHP)	Tranche 2 (PHP)
Z011D	Multiple screw fixation (MSF) 6.5mm cannulated cancellous screws with washer	160,000	144,000	16,000

Table 2: Package Code, Descriptions, Orthopedic Implants and Rates of the Package for Hip Fixation

The following are the *selection* criteria for hip fixation:

a. Any hip fracture not covered under the total hip package for femoral neck fracture
   a.1. *With* no avascular necrosis of the femoral head; OR
   a.2. *Acute* fracture of the hip; OR
   a.3. *Displaced* hip fracture
   a.4. *Undisplaced femoral neck fracture in the elderly*

b. Pre-injury status: ambulatory patients

c. With no more than *two to three (2 to 3)* co-morbid illnesses based on: Physical status classification based on ASA (low to moderate risk)
   c.1. ASA I – Normal healthy patient
   c.2. ASA II - Patient with mild systemic disease; no functional limitation
   c.3. ASA *III- Patient with one or more moderate to severe diseases*

3. Implants for Pertrochanteric fracture

Package Code	Description	Z Package rate per side (left or right) (PHP)	Tranche 1 (PHP)	Tranche 2 (PHP)
Z011E	Compression Hip Screw Set (CHS) OR	150,000	135,000	15,000
Z011F	Proximal Femoral Locked Plate (PFLP) OR	160,000	144,000	16,000
Z011I	Proximal Femoral Nail (PFN)	160,000	144,000	16,000

Table 3: Package Code, Descriptions, Orthopedic Implants and Rates of the Package for Pertrochanteric Facture

The following are the selection criteria for implants for pertrochanteric fractures:

a. CHS: stable fracture of the intertrochanteric area (AO Classification Type A1 fracture)

b. PFLP OR PFN: unstable/comminuted pertrochanteric fracture (AO Classification Type A2 and A3 fracture)

c. Pre-injury status: ambulatory patients

d. With no more than *two to three (2 to 3)* co-morbid illnesses based on: Physical status classification based on ASA (low to moderate risk)
   d.1. ASA I – Normal healthy patient
   d.2. ASA II - Patient with mild systemic disease; no functional limitation
   d.3. ASA *III- Patient with one or more moderate to severe diseases*

4. Implants for Femoral and Tibial Shaft Fracture

Package Code	Description	Z Package rate per side (left or right) (PHP)	Tranche 1 (PHP)	Tranche 2 (PHP)
Z011G1	Intramedullary Nail with Interlocking Screws- Femur	140,000	126,000	14,000
Z011G2	Intramedullary Nail with Interlocking Screws- Tibia	140,000	126,000	14,000
Z011H1	Locked compression plate – broad, metaphyseal, proximal and distal femoral	150,000	135,000	15,000
Z011H2	Locked compression plate – broad, metaphyseal, proximal and distal tibial	150,000	135,000	15,000

Table 4: Package Code, Descriptions, Orthopedic Implants and Rates of the Package for Femoral and Tibial Shaft Fracture

The following are the selection criteria for implants for femoral *and tibial* shaft fracture:

a. Femoral/tibial shaft fracture
   a.1. *Without* malignant/metastatic pathologic fracture; AND
   a.2. *With* any complete fracture of the femur/tibia

b. Pre-injury status: ambulatory patients

c. With no more than *two to three (2 to 3)* co-morbid illnesses based on: Physical status classification based on ASA (low to moderate risk)
   c.1. ASA I – normal healthy patient
   c.2. ASA II - Patient with mild systemic disease; no functional limitation
   c.3. ASA *III- Patient with one or more moderate to severe diseases*

5. *Implants for Total Knee Replacement*

Package Code	*Description*	*Z Package rate per side (left or right) (PHP)*	*Tranche 1 (PHP)*	*Tranche 2 (PHP)*
Z011L	*Knee prosthesis*	*251,000*	*225,900*	*25,100*

Table 5: Package Code, Descriptions, Orthopedic Implants and Rates of the Package for Total Knee Replacement

The following *are the selection criteria for implants total knee replacement:*

a. *Clinical features- Disabling knee pain correlated with radiographic findings; Arthritis consists of articular cartilage, bony changes, and deformity that can result from the following:*
   a.1. *Idiopathic osteoarthritis*
   a.2. *Post-traumatic osteoarthritis*
   a.3. *Avascular necrosis (idiopathic or secondary)*
   a.4. *Inflammatory / crystalline joint disease (rheumatoid, gout, psoriatic, ankylosing spondylitis, SLE)*
   a.5. *Isolated severe patellofemoral arthritis in an elderly patient*

b. *Pre-arthritic status: ambulatory patients*

c. *With no more than two to three (2-3) co-morbid illnesses based on: Physical status classification based on ASA (low to moderate risk)*
   c.1. ASA I – Normal healthy patient
   c.2. ASA II – Patient with mild systemic disease; no functional limitation
   c.3. ASA *III- Patient with One or more moderate to severe diseases*

6. *Implants for Upper Extremities*

Package Code	*Description*	*Z Package rate per side (left or right) (PHP)*	*Tranche 1 (PHP)*	*Tranche 2 (PHP)*
Z011M1	*Arm and Forearm, plating*	*117,000*	*105,300*	*11,700*
Z011M2	*Arm and Forearm, pinning*	*100,000*	*90,000*	*10,000*
Z011N1	*Wrist, plating*	*124,000*	*111,600*	*12,400*
Z011N2	*Wrist, pinning*	*106,000*	*95,400*	*10,600*

Table 6: Package Code, Descriptions, Orthopedic Implants and Rates of the Package for Upper Extremities

The following are the selection criteria for upper extremities: arm and forearm:

The choice between plating and pinning depends on the fracture location, degree of comminution, displacement and age of the patient.

a. *Humerus fractures*
   - *a.1. Proximal and/or;*
   - *a.2. Diaphyseal and/or;*
   - *a.3. Distal*

b. *Forearm diaphyseal fractures*
   - *b.1. Radius only or;*
   - *b.2. Ulna only or;*
   - *b.3. Both Radius and ulna*

c. *Wrist: Distal Radius*

d. *without malignant/metastatic pathologic fracture; AND*

e. *Pre-injury status: functional upper extremity*

f. *With no more than 2-3 co-morbid illnesses based on:*
   Physical status classification based on ASA (low to moderate risk)
   - *f.1. ASA I – normal healthy patient*
   - *f.2. ASA II - Patient with mild systemic disease; no functional limitation*
   - *f.3. ASA III- Patient with one or more moderate to severe diseases*

Q. A maximum of two (2) Z Benefits packages, regardless of laterality for procedures that are done on different dates or on the same day, within the same confinement period, may be availed of by the patient for procedures involving single or multiple injuries requiring more than one implant. Any expenses not covered by the package may be referred to other funding sources or charged to the patient, consistent with co-payment rules.

R. Claims Filing *Schedule*, Reimbursement, *and Tranche Payment*

1. Claims for the Z Benefits for *selected orthopedic implants* must identify the device and components and must bear a code/serial number by which they and their manufacturer may be explicitly identified. The individual code/serial or batch/lot number of each of the implants used is indicated in the operative record of the patient.

2. All claims shall be filed by the contracted *HF*. There shall be NO direct filing by members.

3. In general, the basis for reimbursement shall be the pre-authorization diagnosis *or procedure. However, PhilHealth shall pay the procedure of lower package when a patient underwent an operation other the approved pre-authorized.*

Example:

Pre-authorization diagnosis	Actual procedure done	Reimbursement
Total hip arthroplasty	Partial hip arthroplasty	Partial hip arthroplasty

4. In cases when a procedure *has* a higher package rate *than the pre-authorized one*, payment shall be based on the procedure indicated in the operative record. *As necessary, such claims shall be subject to monitoring or post-audit.*

Example:

Pre-authorization diagnosis	Actual procedure done	Reimbursement
Partial hip arthroplasty	Total hip arthroplasty	Total hip arthroplasty

5. *The payment for selected orthopedic implants shall be given in tranches with the corresponding amounts and filing schedule as follows:*

Description	*Package Code*	Tranche	Amount (Php)	Filing Schedule
I. Implants for Hip Arthroplasty				
A. Total Hip Prosthesis, cemented	*Z011A*	1	*189,000*	*60 days after surgery*
		2	*21,000*	*60 days after the 4th rehabilitation session*
B. Total Hip Prosthesis, cementless	*Z011B*	1	*234,000*	*60 days after surgery*
		2	*26,000*	*60 days after the 4th rehabilitation session*
C. Partial Hip Prosthesis, bipolar	*Z011C*	1	*207,000*	*60 days after surgery*
		2	*23,000*	*60 days after the 4th rehabilitation session*
D. *Total hip prosthesis, hybrid*	*Z011J*	*1*	*207,000*	*60 days after surgery*
		2	*23,000*	*60 days after the 4th rehabilitation session*
E. *Partial hip prosthesis, unipolar modular*	*Z011K*	*1*	*189,000*	*60 days after surgery*
		2	*21,000*	*60 days after the 4th rehabilitation session*
II. Implants for Hip Fixation				
Multiple screw fixation (MSF) 6.5mm cannulated cancellous screws with washer	*Z011D*	1	*144,000*	*60 days after surgery*
		2	*16,000*	*60 days after the 4th rehabilitation session*
III. Implants for Pertrochanteric Fracture				
A. Compression Hip Screw Set (CHS) OR	*Z011E*	1	*135,000*	*60 days after surgery*
		2	*15,000*	*60 days after the 4th rehabilitation session*

Description	*Package Code*	Tranche	Amount (Php)	Filing Schedule
B. Proximal Femoral Locked Plate (PFLP) OR	*Z011F*	1	*144,000*	*60 days after surgery*
		2	*16,000*	*60 days after the 4th rehabilitation session*
C. Proximal Femoral Nail (PFN)	*Z011I*	1	*144,000*	*60 days after surgery*
		2	*16,000*	*60 days after the 4th rehabilitation session*
IV. Implants for Femoral and Tibial Shaft Fracture				
A. Intramedullary Nail with Interlocking Screws - Femur	*Z011G1*	1	*126,000*	*60 days after surgery*
		2	*14,000*	*60 days after the 4th rehabilitation session*
B. Intramedullary Nail with Interlocking Screws - Tibia	*Z011G2*	1	*126,000*	*60 days after surgery*
		2	*14,000*	*60 days after the 4th rehabilitation session*
C. Locked compression plate – broad, metaphyseal, proximal and distal femoral	*Z011H1*	1	*135,000*	*60 days after surgery*
		2	*15,000*	*60 days after the 4th rehabilitation session*
D. Locked compression plate – broad, metaphyseal, proximal and distal tibial	*Z011H2*	1	*135,000*	*60 days after surgery*
		2	*15,000*	*60 days after the 4th rehabilitation session*
V. *Implants for Total Knee Replacement*				
Knee prosthesis	*Z011L*	*1*	*225,900*	*60 days after surgery*
		2	*25,100*	*60 days after the 4th rehabilitation session*
VI. *Implants for Upper Extremities*				
A. *Arm and Forearm, plating*	*Z011M1*	*1*	*105,300*	*60 days after surgery*
		2	*11,700*	*60 days after the 4th rehabilitation session*
B. *Arm and Forearm, pinning*	*Z011M2*	*1*	*90,000*	*60 days after surgery*
		2	*10,000*	*60 days after the 4th rehabilitation session*

Description	*Package Code*	Tranche	Amount (Php)	Filing Schedule
C. *Wrist, plating*	*Z011N1*	*1*	*111,600*	*60 days after surgery*
		2	*12,400*	*60 days after the 4th rehabilitation session*
D. *Wrist, pinning*	*Z011N2*	*1*	*95,400*	*60 days after surgery*
		2	*10,600*	*60 days after the 4th rehabilitation session*

Table 7: Description with Corresponding Package Code, Amount and Filing Schedule Per Tranche Payment for Selected Orthopedic Implants

S. *In cases* when *the patient expires or is lost to follow up anytime during service provision, PhilHealth will only reimburse the corresponding tranche for the specific phase as long as the patient received the scheduled services. After that, however, PhilHealth will not pay for subsequent tranches.*

T. *Patients who are not declared lost to follow-up and returned within four (4) weeks from the advised rehabilitation session may continue the remaining rehabilitations upon re-assessment and referral by the orthopedic surgeon. The rehabilitation services will be covered by the Z Benefits for selected orthopedic implants.*

If the patient returns after four (4) weeks since the scheduled rehabilitation, the patient is no longer eligible to continue the availment of the said Z Benefits for the particular episode of care.

U. *For the initial claim application (i.e., tranche 1), the following shall be attached:*

1. *Transmittal form of claims for the Z Benefits (Annex H) or submission to PhilHealth, per claim or per batch of claims;*
2. *Photocopy of the approved Pre-authorization Checklist and Request while the submission is not yet fully automated;*
3. *Photocopy of the properly accomplished ME Form (Annex B);*
4. *PhilHealth Benefit Eligibility Form (PBEF) printout attached as proof of eligibility during the pre-authorization process (Refer to Section V. A. item nos. 8 and 9);*
5. *Properly accomplished Claim Form 2 (CF2);*
6. *Original or certified true copy of the statement of account (SOA);*
7. *Discharge Checklist for the Z Benefits (Tranche 1) (Annex C.1) for the corresponding tranches;*
8. *Photocopy of completely accomplished Z Satisfaction Questionnaire for services received in Tranche 1 (Annex D); and*
9. *Checklist of Requirements for reimbursement (Tranche 1) (Annex E.1).*

V. *The following documents shall be submitted* for the succeeding claims:

1. Transmittal Form;
2. *Claim Form 2*;
3. *Discharge Checklist for the Z Benefits (Tranche 2) (Annex C.2)*
4. Photocopy of Z Satisfaction Questionnaire (Annex D); *and*

5. Checklist *of Requirements for reimbursement (Tranche 2) (Annex E.2)*

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

X. Rules on late filing shall apply.

Y. 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;

Z. Monitoring

1. Utilization and Compliance

Monitoring of the implementation of Z Benefits package for selected orthopedic implants shall be conducted by PhilHealth.

Field monitoring of service provision by contracted HCPs shall also be conducted. It shall follow the guidance, tools and consent forms provided in the guiding principles of the Z Benefits.

The performance indicators and outcome measures (Annex F) to monitor compliance to the policies of this PhilHealth Circular and the general treatment algorithm (Annex G) are established in collaboration with relevant stakeholders and experts. These shall be incorporated in the relevant monitoring policies of the Corporation.

2. Policy Review

In consultation and collaboration with relevant stakeholders, experts, and technical staff representatives from the Corporation, PhilHealth shall conduct a regular policy review of the Z Benefits for selected orthopedic implants.

AA. 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, and healthcare providers, and other stakeholders, marketing and promotional activities shall be undertaken following the integrated marketing and communication plan of PhilHealth.

BB. List of Annexes (Posted on official PhilHealth website)

1. *Annex A: Pre-authorization Checklist and Request*
   a. *Annex A.1: Pre authorization Checklist and Request for Hip Arthroplasty*
   b. *Annex A.2: Pre authorization Checklist and Request for Hip Fixation*
   c. *Annex A.3: Pre authorization Checklist and Request for Pertrochanteric Fractures*
   d. *Annex A.4: Pre authorization Checklist and Request for Femoral and Tibial Shaft Fractures*
   e. *Annex A.5: Pre authorization Checklist and Request for Total Knee Replacement*
   f. *Annex A.6: Pre authorization Checklist and Request for Upper Extremities*

2. *Annex B: Member Empowerment (ME) Form*

3. *Annex C: Discharge Checklist for the Z Benefits*
   a. *Annex C.1: Orthopedic Implants: Tranche 1*
   b. *Annex C.2: Orthopedic Implants: Tranche 2*

4. *Annex D: Z Satisfaction Questionnaire*

5. *Annex E: Checklist of Requirements for Reimbursement*
   a. *Annex E.1: Orthopedic Implants: Tranche 1*
   b. *Annex E.2: Orthopedic Implants: Tranche 2*

6. *Annex F: Outcome Indicators*

7. *Annex G: Algorithm for Orthopedic Patient Surgical Pathway*

8. *Annex H: Transmittal Form of Claims for the Z Benefits*

The complete list of annexes of the Z Benefits can be found in PhilHealth Circular 2021-0022 "Guiding Principles of the Z Benefits (Revision 1)."

VI. *PENALTY CLAUSE*

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with the pertinent provisions of provisions of Republic Act (RA) No. 7875, as amended by RA Nos. 9241 and 10606; and RA No. 11223, and their respective IRRs, and other relevant laws.

VII. TRANSITORY CLAUSE

A. *Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to contracted HFs, and ensure the availability of revised forms on the PhilHealth website; and*

B. *Claims filed with pre-authorizations that were approved prior to the date of the effectivity of this PhilHealth Circular shall follow the provisions of PhilHealth Circular No. 2016-0020 "Z Benefit Rates for Selected Orthopedic Implants (Revision 1)."*

VIII. SEPARABILITY CLAUSE

If any provision of this PhilHealth Circular shall be declared invalid, unconstitutional, or unenforceable, the validity of the remaining parts or provisions not affected shall remain in full force and enforceable.

IX. REPEALING CLAUSE

This policy repeals PhilHealth Circular No. 2016-0020 "Z Benefit Rates for Selected Orthopedic Implants (Revision 1)."

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days *after* its publication in the Official Gazette or any newspaper of general circulation. A copy shall thereafter be deposited to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
Acting President and Chief Executive Officer (APCEO)

Date signed: 03/27/2023

MASTER COPY
DC: MJS Date: 3/29/23

Annex A.1: Pre authorization Checklist and Request for Hip Arthroplasty

Revised as of March 2023

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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, HF to specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Hip Arthroplasty

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
SURGICAL URGENCY	☐ Emergency: Date/s of surgery (mm/dd/yyyy): _____ ☐ Elective

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	
With no more than *two to three (2-3)* co-morbid illnesses based on physical status classification based on ASA (low to moderate risk)	

CLINICAL FEATURES	**Yes**
Hip fracture: (tick appropriate description): ☐ with avascular necrosis of the femoral head ☐ Neglected fracture of the hip ☐ Hip fracture with pre-existing cox-arthritis ☐ Displaced hip fracture	
With avascular necrosis of the femoral head (FICAT Stage III and IV)	
Hip dysplasia *with subsequent osteoarthritis* (CROWNE I-IV)	
Severe *degenerative* osteoarthritis	
Severe inflammatory joint disease (rheumatoid, gout, psoriatic, ankylosing, spondylitis, *SLE*)	

MASTER COPY Date: 3/29/23 DC: mjs

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

Note:
Once approved, the contracted HF 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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PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Hip Arthroplasty

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z Benefits package for _____ (NAME OF PATIENT) in _____ (NAME OF *HF*) under the terms and conditions as agreed for availment of the Z Benefits package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):

☐ Without co-payment
☐ With co-payment, for the purpose of:
_____
_____

Type of implant being applied for:
☐ Total hip prosthesis (cemented)
☐ Total hip prosthesis (cementless)
☐ Total hip prosthesis (hybrid)
☐ Partial hip prosthesis (bipolar)
☐ Partial hip prosthesis (unipolar/modular)

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon PhilHealth Accreditation No. ____-____-____

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/
Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ____-____-____

MASTER COPY
Date: 3/29/23
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			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 *HF:*			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HF:*		

Annex A.2: Pre authorization Checklist and Request for Hip Fixation

Revised as of March 2023

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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, HF to specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Hip Fixation

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
SURGICAL URGENCY	☐ Emergency: Date/s of surgery (mm/dd/yyyy): _____ ☐ Elective

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II))	
With no more than *two to three (2 to 3)* co-morbid illnesses based on physical status classification based on ASA (low to moderate risk)	

CLINICAL FEATURES	**Yes**
Any hip fracture *not covered under the total hip package for femoral neck fracture:* (tick appropriate description) ☐ Without avascular necrosis of the femoral head ☐ Acute fracture of the hip ☐ Displaced hip fracture ☐ *undisplaced femoral neck fracture in the elderly*	

MASTER COPY Date: 3/29/23 DC: MJS

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

Note:
Once approved, the contracted HF 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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Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Hip Fixation

DATE OF REQUEST (mm/dd/yyyy):

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

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):
☐ Without co-payment
☐ With co-payment, for the purpose of: _____

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon PhilHealth Accreditation No. ____-____-____-____

MASTER COPY
Dt: 3/29/23

Certified correct by:

(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)

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 *HF*:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HF*:		

Annex A.3: Pre authorization Checklist and Request for Pertrochanteric Fractures

Revised as of March 2023

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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, HF to specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Pertrochanteric Fractures

(Place a ✓ opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
SURGICAL URGENCY	☐ Emergency: Date/s of surgery (mm/dd/yyyy): _____ ☐ Elective

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓ if YES, or NA if not applicable)

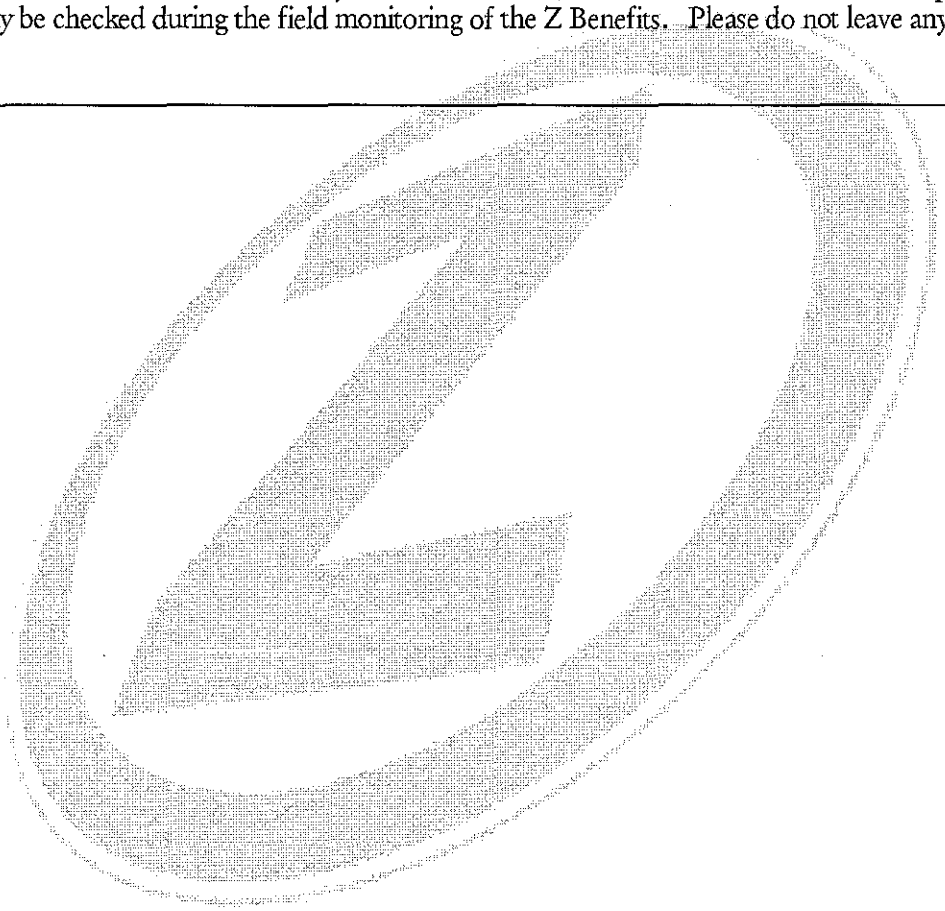
QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II))	
With no more than *two to three (2 to 3)* co-morbid illnesses based on physical status classification based on ASA (low to moderate risk)	

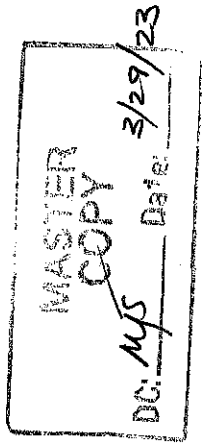
CLINICAL FEATURES	**Yes**
Stable fracture of the intertrochanteric area, classified as Type A1 fracture based on AO classification	
Unstable/comminuted pertrochanteric fracture classified as Type A2 or A3 fracture based on AO classification	

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

Note:
Once approved, the contracted HF 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
Orthopedic Implants: Pertrochanteric Fractures

DATE OF REQUEST (mm/dd/yyyy):

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

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):

- ☐ Without co-payment
- ☐ With co-payment, for the purpose of: _____

Type of implant being applied for:
- ☐ Compression hip screw set
- ☐ Proximal femoral locked plate
- ☐ Proximal femoral nail

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon PhilHealth Accreditation No. ____-____-____

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/
Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ____-____-____

MASTER COPY Date: 3/29/23 DC: mjc

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

Annex A.4: Pre authorization Checklist and Request for Femoral and Tibial Shaft Fractures

Revised as of March 2023

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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, HF to specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Femoral and Tibial Shaft Fractures

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
SURGICAL URGENCY	☐ Emergency: Date/s of surgery (mm/dd/yyyy): _____ ☐ Elective

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

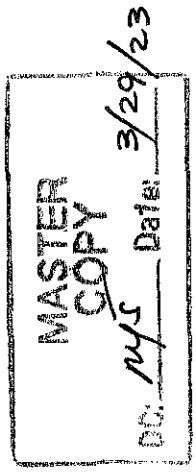
QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	
With no more than *two to three (2 to 3)* co-morbid illnesses based on physical status classification based on ASA (low to moderate risk)	

CLINICAL FEATURES	**Yes**
Femoral shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the femur	
Tibial shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the tibia	

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

Note:
Once approved, the contracted HF 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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PhilHealthOfficial teamphilhealth

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Femoral and Tibial Shaft Fractures

DATE OF REQUEST (mm/dd/yyyy):

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

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):

☐ Without co-payment
☐ With co-payment, for the purpose of:
_____
_____

Type of implant being applied for:
☐ femoral ☐ tibial
☐ Intramedullary nail with interlocking screws
☐ Locked compression plate- broad, metaphyseal, proximal and distal:

MASTER COPY Date: 3/29/23 DC: MJS

Conforme by:

(Printed name and signature)
Patient/Parent/Guardian

Certified correct by:

(Printed name and signature)
Attending Orthopedic Surgeon

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

Certified correct by:

(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)

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 *HF:*			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HF:		

Annex A.5: Pre authorization Checklist and Request for Total Knee Replacement

Revised as of March 2023

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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, HF to specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: *Total Knee Replacement*

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
SURGICAL URGENCY	☐ Emergency: Date/s of surgery (mm/dd/yyyy): _____ ☐ Elective

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	
With no more than *two to three (2 to 3)* co-morbid illnesses based on physical status classification based on ASA (low to moderate risk)	

CLINICAL FEATURES	**Yes**
Disabling knee pain correlated with radiographic findings; Arthritis consists of articular cartilage, bony changes, and deformity that can result from the following: (tick appropriate description) ☐ *Idiopathic osteoarthritis* ☐ *Post-traumatic osteoarthritis* ☐ *Avascular necrosis (idiopathic or secondary)* ☐ *Inflammatory/ crystalline joint disease (rheumatoid, gout, psoriatic, ankylosing spondylitis, SLE)* ☐ *Isolated severe patellofemoral arthritis in an elderly patient*	

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

Note:
Once approved, the contracted HF 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.

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Total Knee Replacement

DATE OF REQUEST (mm/dd/yyyy)::

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

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):
☐ Without co-payment
☐ With co-payment, for the purpose of: _____

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon PhilHealth Accreditation No. ___-_____-_

Certified correct by:

(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)

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 *HF:*			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HF:		

MASTER COPY DC: Mys Date: 3/29/23

Annex A.6: Pre authorization Checklist and Request for Upper Extremities

Revised as of March 2023

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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, HF to specify reason/s and encode _____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Upper Extremities

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
SURGICAL URGENCY	☐ Emergency: Date/s of surgery (mm/dd/yyyy): _____ ☐ Elective

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

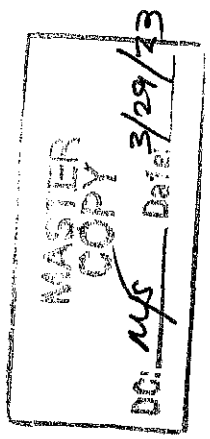
QUALIFICATIONS	**Yes**
Functional upper extremity prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	
With no more than *two to three (2 to 3)* co-morbid illnesses based on physical status classification based on ASA (low to moderate risk)	

CLINICAL FEATURES	**Yes**
Arm and Forearm: The choice between plating and pinning depends on the fracture location, degree of comminution, displacement and age of the patient. ☐ Humerus fractures (proximal and/or; distal and/or; distal) ☐ Forearm diaphyseal fractures (radius only or; Ulna only or; both radius and ulna) ☐ Wrist (distal radius) ☐ Without malignant/metastatic pathologic fracture;	

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

Note:
Once approved, the contracted HF 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.



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: *Upper Extremities*

DATE OF REQUEST (mm/dd/yyyy):

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

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):

☐ Without co-payment
☐ With co-payment, for the purpose of:
_____
_____

Type of implant being applied for:

☐ *Arm and forearm, plating*
☐ *Arm and forearm, pinning*
☐ *Wrist, plating*
☐ *Wrist, pinning*

Conforme by:

(Printed name and signature)
Patient/Parent/Guardian

Certified correct by:

(Printed name and signature)
Attending Orthopedic Surgeon
PhilHealth Accreditation No. | | | | | – | | | | | | | – | | |

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/
Medical Director/ Medical Center Chief
PhilHealth Accreditation No. | | | | | – | | | | | | | – | | |

RECEIVED BY: mjs Date: 3/29/23

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

COMPLIANCE TO REQUIREMENTS

☐ APPROVED
☐ DISAPPROVED (State reason/s)

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

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PhilHealthOfficial teamphilhealth

Numero ng kaso: _____
Case No.

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 pagpapárami ng kopya ng ME Form.
   The ME form shall be reproduced by the contracted health facility (HF) 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 HF—one for the patient and one as file copy of the contracted HF providing the specialized care.
7. **Para sa mga pasyenteng gagamit ng Z Benefit for Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, o Z Benefits para sa mga batang may kapansanan, isulat ang N/A sa tala B2, B3 at D6. Para naman sa Peritoneal Dialysis (PD) First Z Benefits, isulat ang N/A para sa tala B2 at B3.**
   For patients availing of the Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH) for fitting of the external lower limb prosthesis, or Z Benefits for children with disabilities, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

PANGALAN NG OSPITAL *HEALTH FACILITY (HF)*
ADRES NG OSPITAL *ADDRESS OF HF*

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

WALK-IN COPY Date: 3/29/23 DC: MJS

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 HF 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 HF or consult[b] (mm/dd/yyyy)* [b] Para sa ZMORPH/ mga batang may kapansanan, ito ay petsa ng paglalapat at pagsasayos ng device. Para naman sa PD First, ito ay ang kasunod na pagbisita sa PD Provider. *[b] For ZMORPH/CWDS, this refers to the measurement, fitting and adjustments of the device. For the PD First, this refers to the next visit to the PD Provider.*	
3. 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.*	

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 N.A 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 HF of my choice and that preferring another contracted HF 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 HF 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 HF may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		

Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi naunkol *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 HFs 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*		

MASTER COPY Date: 3/29/23

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.*		

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 N.A 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 HF 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)*

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 HF*		
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*

PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
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DISCHARGE CHECKLIST FOR THE Z BENEFITS
Orthopedic Implants
Tranche 1

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

(Place a ✓opposite appropriate answer)

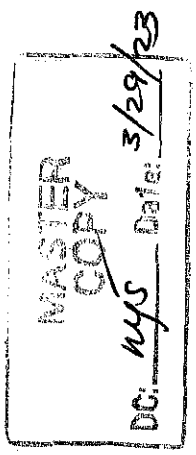
IMPLANT PROVIDED (max of 2)	**RIGHT**	**LEFT**	**BOTH**
☐ Total hip prosthesis, cemented			
☐ Total hip prosthesis, cementless			
☐ Partial hip prosthesis, bipolar			
☐ Total hip prosthesis, hybrid			
☐ Partial hip prosthesis, unipolar modular			
☐ Multiple screw fixation, 6.5 mm cannulated cancellous screws with washer			
☐ Compression hip screw set			
☐ Proximal femoral locked plate			
☐ *Proximal femoral nail*			
☐ Intramedullary nail with interlocking screws-*Femur*			
☐ *Intramedullary nail with interlocking screws-Tibia*			
☐ Locked compression plate – broad, metaphyseal, *proximal* and distal femoral			
☐ *Locked compression plate – broad, metaphyseal, proximal and distal tibia*			
☐ Knee prosthesis			
☐ Arm and forearm, plating			
☐ Partial hip prosthesis, pinning			
☐ Wrist, plating			
☐ Wrist, pinning			

MASTER COPY 3/29/23 Date

(Place a ✓ if DONE)

MANDATORY SERVICES	
1. Orthopedic implant/s provided is/are as prescribed.	
2. The individual code/serial or batch/lot number of each of the implants used is indicated in the Operative Technique of the patient.	
3. The discharge plan is given and explained to the patient.	

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



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DISCHARGE CHECKLIST FOR THE Z BENEFITS
Orthopedic Implants
Tranche 2

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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 ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

(Place a ✓ opposite appropriate answer)

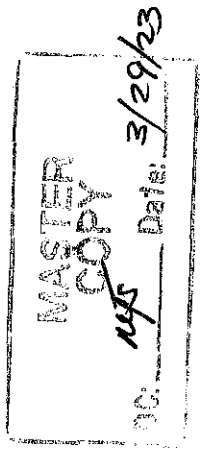
IMPLANT PROVIDED	RIGHT	LEFT	BOTH
☐ Total hip prosthesis, cemented			
☐ Total hip prosthesis, cementless			
☐ Partial hip prosthesis, bipolar			
☐ Total hip prosthesis, hybrid			
☐ Partial hip prosthesis, unipolar modular			
☐ Multiple screw fixation, 6.5 mm cannulated cancellous screws with washer			
☐ Compression hip screw set			
☐ Proximal femoral locked plate			
☐ *Proximal femoral nail*			
☐ Intramedullary nail with interlocking screws-*Femur*			
☐ *Intramedullary nail with interlocking screws-Tibia*			
☐ Locked compression plate – broad, metaphyseal, *proximal* and distal femoral			
☐ *Locked compression plate – broad, metaphyseal, proximal and distal tibia*			
☐ Knee prosthesis			
☐ Arm and forearm, plating			
☐ Partial hip prosthesis, pinning			
☐ Wrist, plating			
☐ Wrist, pinning			

(Place a ✓ if DONE)

REHABILITATION SESSIONS	DATES PERFORMED (min of 4 per package)				
Physical therapy OR occupational therapy	Package 1				
	Package 2 (for multiple injury)				

FOLLOW UP VISIT	Date:

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



PhilHealth Benefits

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 facility 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

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 facility (HF) 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 HF expenses been lessened by availing of the Z benefit package?
   - ☐ less than half
   - ☐ by half
   - ☐ more than half
   - ☐ don't know

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

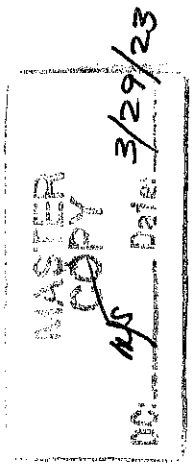
9. If you have other comments, please share them below:

   _____

   _____

   _____

Thank you. Your feedback is important to us!



_____

Signature of Patient/ Parent/ Guardian

Date accomplished: _____

Annex E.1: Checklist of Requirements for Reimbursement (Tranche 1)

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Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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)

Selected Orthopedic Implants

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E.1)	
2. Photocopy/ies of approved Pre-Authorization Checklist/s & Request/s (Annex A)	
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 (Tranche 1) (Annex C.1)	
6. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
7. Photocopy of operative report	
8. Photocopy of anesthesia report	
9. Original or certified true copy of the Statement of Account	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Orthopedic Surgeon	(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: 3/29/23

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Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
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)
Selected Orthopedic Implants

Requirements	Please Check
1. Checklist of Requirements for Reimbursement (Annex E.2)	
2. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
3. Checklist of mandatory and other services (Tranche 2) (Annex C.2)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
5. Original or certified true copy of the Statement of Account	

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: 3/29/23

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OUTCOME INDICATORS FOR SELECTED ORTHOPEDIC IMPLANTS

I. Morbidity (infection, implant failure, other complications)

II. Mortality

III. Patient reported outcome measures

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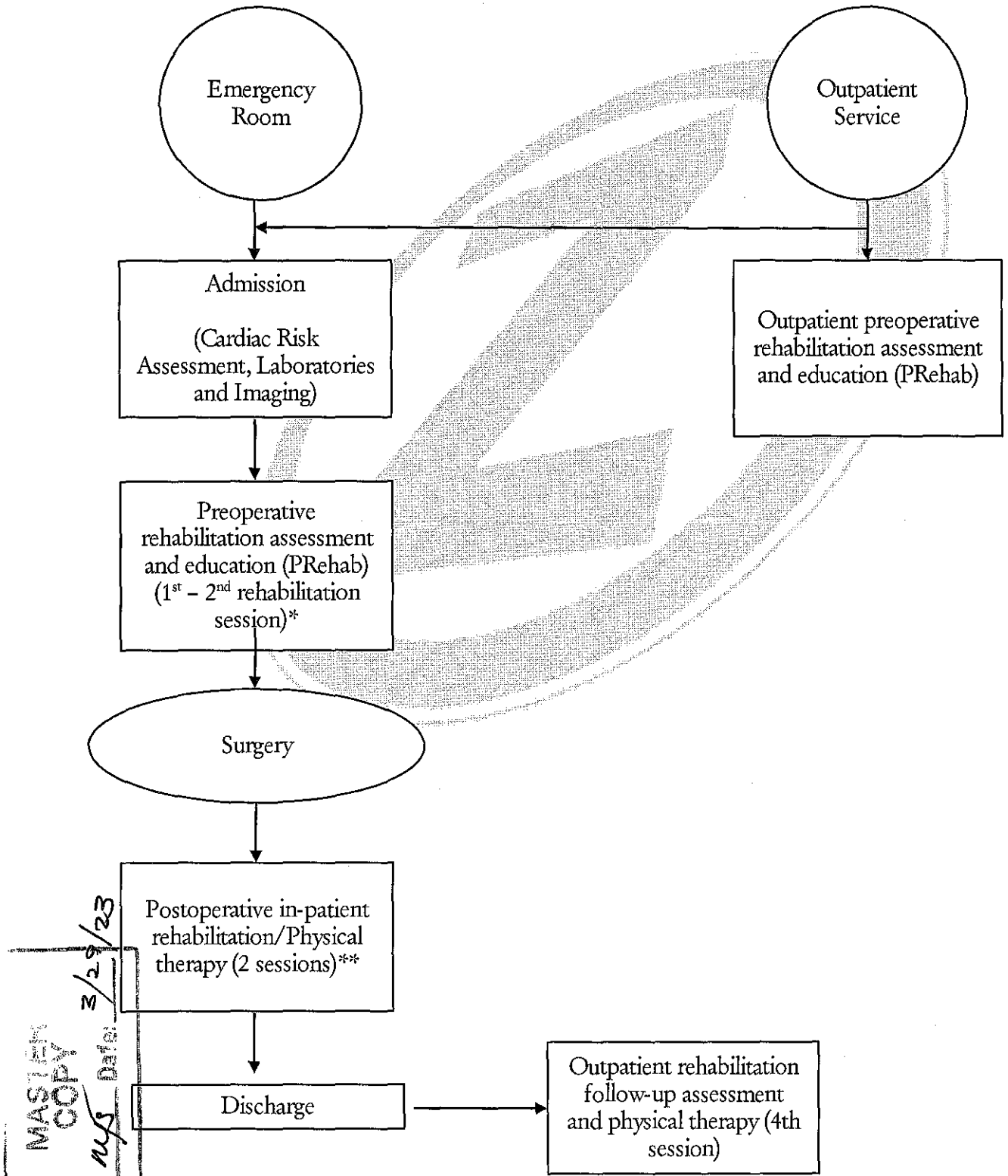
Algorithm for Orthopedic Surgery



*the number of sessions may vary based on the case of each of the patients
**or number of succeeding rehabilitation sessions based on the management protocol of patient.
Note: The Z Benefits for selected orthopedic implants cover only four rehabilitation sessions.

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TRANSMITTAL FORM OF CLAIMS FOR THE Z BENEFITS

NAME OF CONTRACTED HEALTH *FACILITY*	ADDRESS OF *HF*

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

MASTER COPY 3/29/23 Date
DC: WJS

	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						

Certified correct by authorized representative of the *HF*		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)		