



Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

- Citystate Centre, 709 Shaw Boulevard, Pasig City
- (02) 8662-2588 ⊕ www.philhealth.gov.ph
- PhilHealthOfficial X teamphilhealth

PHILHEALTH CIRCULAR

No. 2024 - 0007

TO

ALL CONTRACTED HEALTH FACILITIES FOR THE Z

BENEFITS FOR BREAST CANCER, AND ALL OTHERS

CONCERNED

SUBJECT

Z Benefits Package for Breast Cancer

RATIONALE I.

Breast cancer stands as a substantial health concern in the Philippines, posing a considerable burden to individuals affected by such illness. It ranks among the most prevalent cancers affecting Filipino women, with rising incidence rates. The disease not only leads to substantial mortality but also imposes a financial burden on affected individuals and families due to expensive treatments and prolonged healthcare needs.

In 2012, PhilHealth introduced the Z Benefits, one of which was a specific benefit package for breast cancer. PhilHealth's coverage of breast cancer aims to alleviate this burden by providing financial risk protection through a comprehensive benefit package. The primary objective is to reduce the financial barrier faced by patients and promote timely intervention, ultimately improving outcomes and quality of life for affected individuals and their families.

Thus, PhilHealth Board Resolution (PBR) No. 2883 series of 20241 approved the enhancement of the Z Benefits Package for Breast Cancer, which expands the coverage of service and treatment to address the health needs of the patients dealing with breast cancer.

II. **OBJECTIVES**

This PhilHealth Circular aims to define the policies and procedures for implementing the Z Benefits Package for Breast Cancer.

III. SCOPE

This PhilHealth Circular shall apply to all contracted health facilities (HFs) that deliver the minimum standard of care for breast cancer and all others involved in its implementation.

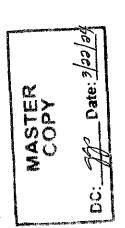
¹ PhilHealth Board Resolution (PBR) No. 2883 series of 2024: The enhancement of coverage of the Z Benefits Package for Breast Cancer





IV. DEFINITION OF TERMS

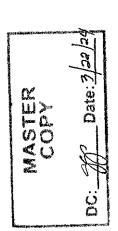
- **A.** Basic or Ward Accommodation² refers to the provision of regular meals, bed in shared room, fan ventilation, and shared toilet and bath.
- **B.** Case-based Provider Payment Mechanism refers to a provider payment system in which a hospital is reimbursed at a predetermined rate for each of the treatment phases or services rendered during the medical treatment given to an individual.
- C. Contracted Health Facility (HF) refers to a PhilHealth-accredited health facility that enters into a contract with PhilHealth for the provision of specialized care for the Z Benefits.
- **D.** Co-payment refers to a flat fee or predetermined rate paid at a point of service, as may be determined by PhilHealth. This amount will be charged to patients as their share for amenities or any additional or upgrade of services beyond the coverage of the benefits package. Co-payments shall have a fixed limit or cap but not exceeding the corresponding rate of the Z Benefits package. These co-payment rates shall be subject to negotiation by PhilHealth to determine the applicable rates and ensure financial risk protection of the members/dependents.
- E. Cost-sharing refers to the direct payment of a portion of health care cost by the members/dependents when receiving health services. This term generally includes deductibles, coinsurance, and co-payments, or similar charges.
- F. Electronic Medical Record (EMR) or Electronic Health Record (EHR) refers to a digital collection of medical information about a person helpful in making clinical recommendations or decisions and providing data on episodes of care that could indicate resource intensity use and information pertinent to healthcare costs.
- **G. Fee Schedule** refers to a predetermined list of fees or charges that outlines the prices or reimbursements for various medical procedures, services, or treatments. This list of items with equivalent rate is used to reimburse healthcare providers on a fee-for-service with a cap or a case-based payment mechanism.
- H. Fluorescence in Situ Hybridization³— refers to a confirmatory test for HER2 that is done on breast cancer tissue removed during biopsy to check the DNA of the cancer cells for extra copies of the Her2/neu genes. Patients may avail of the FISH (fluorescence in situ hybridization) and the immunohistochemistry (IHC) HER2/neu test under the Breast Cancer Z Benefit diagnostic tests and prognostication package. If the IHC test or the FISH test is positive, then the patient can be given drugs that target the HER2/neu protein (e.g., trastuzumab), stopping the cancer cell from growing.



² DOH AO No. 2021-0015: Standards on Basic and Non-basic Accommodation in All Hospitals

³ https://www.cancer.gov/publications/dictionaries/cancer-terms/def/fluorescence-in-situ-hybridization

- I. Human Epidermal Growth Factor Receptor 2 (HER2/neu) Immunohistochemistry (IHC) Test4 refers to a component of the breast panel under the diagnostic test and prognostication package of the Z Benefits that measures the amount of human epidermal growth factor receptor 2 (HER2) protein on cancer cells. Patients with HER2-positive breast cancer are candidates for chemotherapy and targeted therapy.
- **J.** Lost to Follow-up refers to a term used to characterize a breast cancer patient who has not returned to or followed up at a contracted health facility after sixty (60) calendar days from the scheduled visit or treatment, as advised.
- **K.** Member Empowerment (ME) Form refers to 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.
- **L. Minimum Standards of Care** refer to the essential services that the contracted HFs are obliged to provide based on clinical practices guidelines or current best practices in the local setting.
- M. Multidisciplinary-Interdisciplinary Team (MDT) Approach refers to an approach to patient care involving team members from different professional backgrounds or work disciplines, with each member providing specific services while working collaboratively together to provide the best care to the patient.
- N. Multidisciplinary Patient Care⁵ refers to an integrated approach to cancer care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient.
- **O. Pre-authorization** refers to 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.
- P. Shadow Billing for Diagnosis-Related Group (DRG)⁶ refers to the process whereby PhilHealth will provide sufficient time to allow accredited HF to adjust to the new rules in claims submission in preparation for the transition to a DRG system while following the All Case Rates (ACR) payment method to minimize disruptions in claims processing.



⁴ https://www.cancer.gov/publications/dictionaries/cancer-terms/def/her2-neu-test

⁵ Republic Act No. 11215: National Integrated Cancer Control Act

⁶ PhilHealth Circular 2023-0014: Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG)

Q. Surveillance⁷ – refers to an ongoing assessment of an early signs of relapse or evaluation of an individual who appears to be clinically stable, treated or not progressing. In public health, surveillance may also refer to the ongoing systematic collection and analysis of information about the incidence, prevalence, morbidity, survival, and mortality related to a disease or health-related event in a certain group of people.

V. POLICY STATEMENTS

A. Benefits Availment

- t. The members/dependents shall undergo consultation and clinical breast examination for any abnormalities, lumps, and other relevant signs and symptoms by the attending physician. The contracted HF shall defer receiving any payments from individuals who are eligible to avail of the diagnostic tests based on all of the following criteria:
 - a. Positive (+) breast mass AND/OR palpable axillary lymph node;
 - b. BI-RADS category 4 to 5 result of either mammogram or ultrasound; and
 - c. Biopsy result of confirmed malignant breast cancer or ductal carcinoma in situ (DCIS).

The Checklist of Eligibility Criteria for Diagnostic Tests - Breast Cancer is specified in Annex A.1.

- 2. The diagnostic tests of patients conducted at the contracted HF shall adhere to the eligibility criteria outlined in Section V.A.1 to qualify for the benefits coverage of PhilHealth.
- 3. The applicable benefits package under the All Case Rates (ACR) shall cover the procedure of biopsy with histopathology. If the result confirms a malignant tumor, the contracted HF may proceed to provide prognostication services to the patient.
- 4. The Multidisciplinary-Interdisciplinary Team (MDT) of the contracted HF shall assess and evaluate patients diagnosed with breast cancer to determine the appropriate treatment protocol before seeking preauthorization approval from PhilHealth.
- 5. The following are the selection criteria for pre-authorization:
 - a. Breast cancer clinical stage requiring treatments that are covered under the Z Benefits:
 - a.1. Stage o Ductal Carcinoma in Situ (DCIS)
 - a.2. Stage I
 - a.3. Stage II

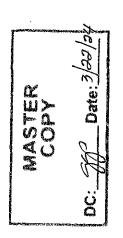
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⁷ https://www.cancer.gov/publications/dictionaries/genetics-dictionary/def/surveillance; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6366832/#R1

- a.4. Stage III
- a.5. Stage IV
- b. Breast cancer management involving any or all of the following phases:
 - b.1. Surgery
 - b.2. Chemotherapy (neo/adjuvant): patient has not initiated any chemotherapy treatment from any HF
 - b.3. Targeted therapy
 - b.4. Hormonotherapy
 - b.5. Surveillance
- 6. Pre-authorization from PhilHealth is necessary before providing services such as surgery, systemic therapy (cytotoxic chemotherapy, hormonotherapy, and targeted therapy), and surveillance to patients with breast cancer. The Pre-authorization Checklist and Request Form (Annex A.2) outline the clinical criteria for benefits availment.
- 7. While the submission of the Pre-authorization Checklist and Request Form is not yet fully automated, the designated liaison of the contracted HF shall submit the complete and properly accomplished original copy of the Pre-authorization Checklist and Request Form, a photocopy of the properly accomplished Member Empowerment Form or ME Form (Annex B), and photocopy of the MDT plan to the Local Health Insurance Office (LHIO) or the office of the Head of the PhilHealth Benefits Administration Section (BAS) with jurisdiction over the contracted HFs. These documents may also be scanned and emailed to the respective PROs for approval.
- 8. The selection criteria shall serve as the bases for PhilHealth's approval of the pre-authorization request submitted by the contracted HF. Once pre-authorization is approved, the patient shall be entitled to the necessary care and services within the coverage of the benefit package as prescribed by the MDT in the treatment plan.
- 9. PhilHealth members and their qualified dependents must be eligible to avail of PhilHealth benefits at the time of pre-authorization approval. All contracted HFs should remind these patients to update their membership profiles and premium contributions as part of their obligations.
- 10. The PhilHealth Benefit Eligibility Form (PBEF) shall be the primary proof of benefit eligibility. A "Yes" response shall mean that the member is entitled to avail of the Z benefits. As such, the contracted HFs shall no longer require proof of contribution for claims availment. While a "No" response would require the patient to register or apply for a PhilHealth Identification Number (PIN) prior to pre-authorization.
- 11. The approved Pre-authorization Checklist and Request Form shall be valid for sixty (60) calendar days from the date of approval by PhilHealth if there are no treatments initiated for chemotherapy (if neoadjuvant treatment) or surgery (if adjuvant treatment). All contracted HFs shall monitor the



- validity of their approved pre-authorization and promptly notify PhilHealth upon the lapse of its validity.
- 12. In case of expiration of pre-authorization, the contracted HFs shall submit a new pre-authorization checklist and request. It will include reassessing the patient's clinical cancer staging as necessary.
- 13. In case of fortuitous events or natural calamities, PhilHealth shall accord an extension of ninety (90) days for surgery and fourteen (14) days for chemotherapy reckoned from the date of approval of the preauthorization.
- 14. The ME Form shall be accomplished together by the attending health care professional/s in the contracted HFs and the patient for enrolment in the Z benefits for breast cancer. The ME Form aims to support patients as active participants in healthcare decision-making by being educated and informed of the conditions and management options. Further, the ME Form encourages the attending healthcare professionals in the contracted HFs to dedicate adequate time to discuss with patients to achieve better health outcomes and patient satisfaction.
- 15. The contracted HF shall thoroughly discuss the cost-sharing aspect with the patient during the administration of the ME form. Moreover, the contracted HF shall inform the patient of any additional charges for amenities or upgrade of services not covered by the Z Benefits package
- 16. The patient may be charged applicable cost-sharing based on the corresponding service, treatment, cycle, or procedures. Such cost-sharing shall be payable at the point of service in a specific treatment, session, cycle, or service.
- 17. No co-payment shall be charged for services rendered on patients admitted in basic or ward accommodation. However, if they would opt for amenities, such as an upgrade of room accommodation or additional services not covered by PhilHealth, contracted HFs may charge co-payment that shall not exceed the rates prescribed in the contract for a specific service. The ME Form serves as the document of the agreement on co-payment between the patient and the contracted HF.
- 18. Patients enrolled for surgery, systemic therapy, or surveillance shall have a maximum deduction of five (5) days from the forty-five (45) day annual benefit limit, regardless of the patient's treatment phase. Such deductions are applicable only in the current year when the pre-authorization is approved.
- 19. If the remaining annual benefit is at least one (1) day at the time of preauthorization application, the member shall remain eligible to avail of the Z Benefits. No further deductions shall be made on the 45-day annual benefit limit while enrolled under the Z benefits.



- 20. No deductions shall apply to the forty-five (45) day annual benefit limit for members/dependents eligible to undergo diagnostic tests or prognostication.
- 21. Patients currently undergoing treatment for breast cancer may qualify for enrollment in the Z Benefits package. The contracted HF may enroll the patient at any of the treatment phases by submitting a pre-authorization request in accordance with the following rules:
 - a. Members/dependents with ongoing treatment for targeted therapy and hormonotherapy can continue these specific treatments under the coverage provided by the Z Benefits for the remaining sessions or duration of their treatment.
 - b. Patients diagnosed with contralateral (opposite-side) breast cancer are eligible to undergo surgical procedures covered by Z Benefits six (6) months after their initial surgery.
 - c. Patients who have completed their chemotherapy cycles at a health facility.

Patients shall fully disclose any previous or ongoing treatments from any health facilities. The contracted HF shall ensure that the patient qualifies with the selection criteria and submit the mandatory requirements for preauthorization as prescribed in this policy, including the MDT plan detailing the continuation of the treatment phases.

- 22. The Z Benefits shall not cover ongoing chemotherapy sessions for patients in the non-contracted HF. These patients shall complete the required cycles or sessions of chemotherapy before enrollment in the Z Benefits.
- 23. Patients who have undergone surgical procedures, whether or not covered by the Z Benefits package, and subsequently require surgical procedures on the ipsilateral (same side) breast due to cancer recurrence shall be covered under the All Case Rate (ACR).
- 24. Patients who have undergone surgical procedure under the Z Benefits package and require surgical procedures on the contralateral breast (opposite side) within the period of six (6) months after post-surgery shall be covered under the regular benefits.
- 25. Patients who underwent a procedure or treatment of breast cancer may avail of the surveillance packages at the contracted HF to monitor their condition and detect any potential recurrence or progression of the disease.
- 26. In cases of patient transfer due to non-renewal of contract of the contracted HF, change of address, or patient's choice, among others, the contracted HF shall refer or transfer their patient(s) to another HF that is contracted for the Z Benefits for breast cancer to facilitate the continuation of their treatment. The referring contracted HF shall accomplish the



following documents for submission to the referral contracted HF and PhilHealth:

- a. Properly accomplished ME Form (Annex D);
- b. Breast Cancer Treatment Passport (Annex F);
- c. Checklist for Patient Transfer (Annex G);
- d. Letter of Intent for Transfer (Annex I);
- e. Photocopy of approved Pre-authorization Checklist and Request;
- f. Photocopy of MDT plan; and
- g. Photocopy of Medical abstract

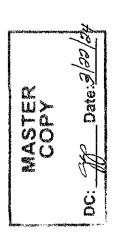
The referral contracted HF shall discuss any applicable co-payment for treatment or services to the patient prior to transfer to the facility for continuation of care under the Z Benefits. The contracted HF shall indicate the co-payment in the newly accomplished ME Form.

27. Patients with ongoing treatment for systemic therapy under the Z Benefits shall be permitted to transfer to another contracted HF based on the following circumstances:

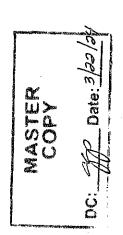
Systemic Therapy	Allowed Schedule for Transfer
Cytotoxic Chemotherapy	After completion of the required cycles
Targeted Therapy	After 6th cycles (equivalent to 1 tranche)
Hormonotherapy	After 6th month prescription (equivalent to 1 tranche)

Table 1: Patient Transfer Schedule

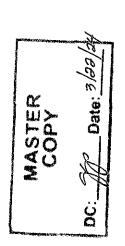
- 28. Members/dependents who are not yet declared lost to follow-up and returned within sixty (60) days from the advised scheduled visit or treatment may continue the sessions, cycles, treatment, or services under the Z Benefits upon reassessment of the MDT and/or attending physicians, as applicable.
- 29. Patients who were already declared lost to follow-up and intend to continue the sessions, cycles, treatment, or services under the Z Benefits shall be required to undergo pre-authorization application and approval, subject to specific rules for availing the benefits.
- B. Patient Management and Standards
 - 1. The Z Benefits shall cover medical interventions for individuals diagnosed with breast cancer falling within the selection criteria, provided that the treatment aligns with the protocol of the Z Benefits Package for Breast Cancer.



- The contracted HFs shall establish a streamlined process for assessing breast cancer patients and ensuring that patients who meet the selection criteria shall be entitled to access the benefits package.
- 3. The contracted HFs shall ensure efficiency and adherence to the patient selection criteria, guaranteeing that eligible patients avail of the benefit. The selection criteria ensure access to comprehensive care for breast cancer, supported by an evidence-based approach, to facilitate the efficient delivery of care and services.
- 4. The contracted HFs shall conduct an assessment and evaluation of breast cancer patients prior to enrollment in the Z Benefits. The MDT shall be composed of a medical oncologist, radio-oncologist, surgeon, pathologist, and radiology consultant. Their combined expertise ensures a comprehensive assessment and evaluation of the patient's condition and medical management.
- 5. The MDT approach is mandatory before initiating any treatment modality, and adherence to this approach is essential for all patient care covered under the Z Benefits. The MDT shall discuss the treatment plan of the patient prior to the pre-authorization application for the Z Benefits. The treatment plan shall be attached to the pre-authorization checklist and request form in accordance with Section V.A.6 of this policy. The whole cycle of care under Z Benefits may be availed of by the patient according to the rules prescribed per treatment phase during pre-authorization.
- 6. The patient's management shall proceed according to the MDT-approved treatment plan. Should there be a deviation from the MDT plan, the contracted HF shall attach a certification detailing the changes in the patient treatment plan upon submission of claims for reimbursement. The MDT shall affix their signature in the certification.
- 7. In case of a member/dependent who has an ongoing treatment for breast cancer, the MDT who is/are responsible for the specific treatment phases shall be required to submit an approved MDT treatment plan for the continuity of care as an attachment to pre-authorization for enrolment to the Z Benefits.
- 8. The patient may undergo neoadjuvant or adjuvant treatment as prescribed in the approved MDT treatment plan. For patients who are undergoing neoadjuvant chemotherapy, the medical oncologist shall fully administer the chemotherapy before any surgical intervention is initiated or performed.
- 9. PhilHealth shall reimburse surgical procedures involving both breasts on the same surgical operation date within the same confinement period at a fixed rate of one surgical procedure. The Z Benefits Package for breast cancer covers the management of post-operative complications associated with breast surgery that occur during the same confinement period.



- 10. In cases of bilateral surgical procedures occurring on different operation dates within the same confinement period due to contraindications, among others, shall be reimbursed at a fixed rate of one surgical procedure. The contracted HF may charge co-payment, except for patients admitted in basic or ward accommodation.
- 11. Any medical complications resulting in hospital confinements occurring after patient discharge that are secondary to other conditions or comorbidities shall be under the coverage of the applicable benefits of PhilHealth.
- 12. The medical oncologist shall be responsible for the drug management of the systemic therapy (hormonotherapy, targeted therapy, and chemotherapy), including planning, administration, and monitoring of drug therapeutic and safety effects.
- 13. The MDT or attending physician shall record all of the systemic therapy administered to a patient in the Breast Cancer Treatment Passport (Annex F).
- 14. The contracted HFs shall ensure the availability of the medicines in their pharmacy, including medical supplies, to prevent them from running out of stock.
- 15. The benefits package under the ACR shall cover the radiotherapy treatment of the patient.
- 16. All contracted HFs shall facilitate radiotherapy and biopsy services for their Z patients by coordinated referrals to other PhilHealth-accredited facilities, if applicable.
- 17. Contracted HFs for the Z Benefits on breast cancer are required to have a medical record of all their patients, preferably an Electronic Medical Record (EMR). For standardization, PhilHealth shall set the contents of the EMR in collaboration with experts on breast cancers and pertinent stakeholders. It should contain the quality indicators that PhilHealth shall require for monitoring, policy research, and quality improvement.
- 18. Once a cancer registry database is functional, PhilHealth shall develop a system capable of exchanging health information across all accredited or contracted HFs and integrate the analytical tools or information in the database for its interoperability.
- 19. PhilHealth shall establish quality standards and indicators in collaboration with the contracted HF, clinical experts, and other pertinent stakeholders. All contracted HFs for the Z Benefits for breast cancer 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 based on current evidence and clinical practice guidelines.



- 20. PhilHealth shall monitor all patients availing of the Z Benefits for breast cancer for all clinically relevant outcomes. In addition, claims of contracted HFs may be subject to post-audit by PhilHealth.
- 21. The contracted HFs shall document the patients' dropout, post-surgery complications, and drug adverse effects to provide the appropriate study and analysis in the context of quality healthcare. Contracted HFs should conduct the appropriate study and analysis of all their enrolled patients in the Z Benefits to enhance the quality of services.
- 22. Accredited public and private HFs shall participate in the shadow billing for diagnosis-related groups (DRGs) following PhilHealth Circular 2023-0014, "Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG)" and its succeeding revisions, as applicable.

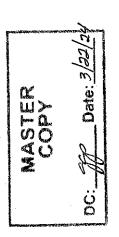
C. Z Benefits Coordinator for Breast Cancer

The contracted HFs shall be required to designate at least one (1) Z Benefits Coordinator for the Z Benefits for breast cancer, whose responsibilities may include, but are not limited to the following, as may be deemed necessary by the contracted HF:

- Guide and navigate Z patients by facilitating timely access to the services required for the Z Benefits. Guiding Z patients enrolled in the program aims to overcome healthcare barriers in the availment of the said benefits to ensure patient adherence to agreed treatment plans to achieve good clinical outcomes and ultimate patient satisfaction.
- 2. Coordinate with PhilHealth on matters pertinent to the Z Benefits availment of candidate patients, such as filling out forms and assessing eligibility requirements before pre-authorization and providing feedback and other inputs required by PhilHealth.
- 3. Encode pertinent clinical information and other data (i.e., demographics, etc.) of all patients diagnosed with breast cancer, whether or not the patient fulfills the selection criteria for pre-authorization.

Once the Z Benefits and Information Tracking System (ZBITS) is in place, the Z Benefits coordinator shall enter pertinent data elements of all patients with approved Pre-authorization Checklist and Request (Annex A) in the required fields of the ZBITS Module in the HF Portal. PhilHealth shall determine the data elements in collaboration with the contracted reference HF, experts on breast cancer, and other stakeholders. Contracted HFs shall train their respective Z Benefits coordinator/s.

Other duties and responsibilities are ensuring completeness and accuracy of all document attachments required for pre-authorization and claims application for reimbursement and coordination with PhilHealth, which shall facilitate the implementation of the Z Benefits.



D. Contracting of Health Facilities

- PhilHealth shall contract capable accredited health facilities to render the services of Z Benefits for Breast Cancer. The contracted HFs are mandated to be capable of delivering all of the mandatory and other services as the minimum standards of care for all breast cancer patients enrolled under the Z Benefits.
- 2. The contract shall contain the additional terms and conditions between PhilHealth and the health facility that will provide the services under the Z Benefits package for Breast Cancer.
- 3. The accredited HF shall exclude targeted therapy from the co-payment proposal prior to contracting. Accredited HFs may refer to "Annex O" regarding the co-payment proposal for each of the services or treatment phases for the Z Benefits package for breast cancer, subject to negotiation and approval of PhilHealth.
- 4. The accredited HF shall identify the additional services, amenities, or procedures necessary for the patient's treatment not covered by the benefit package. They shall indicate the amount of the applicable co-payment in the contract based on the offered services outside the benefits package.
- 5. Contracted HFs with an existing contract for the Z Benefits package for breast cancer shall update their co-payment proposal as stated in Section V.D. of this policy.

E. Mandatory or the Minimum Standards of Care

1. Diagnostic Tests and Prognostication

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Diagnostic Tests and Prognostication			
Mandatory Services			
a. Diagnostic Test	a.1. Diagnostic Tests		
	a.1.1. Mammography abf a.1.2. Ultrasound acf		
	a.1.3. Clinical Consultation (Physical Examination and History)		
b. Prognostication	b.1. Breast Panel dg		
	b.1.1. Complete Blood Count with Platelet Count		
	b.1.2. ER/PR Hormone Test		
	b.1.3. Her2/neu Immunohistochemistry (IHC) Test		
	b.1.4. Metabolic Panel with Liver Function Tests		
	b.1.5. Alkaline Phosphatase		

Mandatory Services b.2. Fluorescent in situ hybridization (FISH) for Her2/neu amplification eg

Legend:

^a Any of the following for Female less than 40 years old

^b Required for all female 40 years old and above

c Ultrasound of both breast and axillary bed for male patient

^d Biopsy with histopathology result of malignancy is required to avail the benefits under the prognostication (Breast panel); Maximum availment of one (1) before preauthorization

^eRequired when the Immunohistochemistry (IHC) result is 2+, the HER2 status of the tumor is not clear and is called "equivocal", maximum of one (1) availment prior enrolment for pre-authorization

^f Maximum of one (1) availment if the patient qualifies for the eligibility criteria before pre-authorization

8 Not applicable for Stage o DCIS

Table 2: Diagnostic Tests and Prognostication

2. Surgical Procedures

Descriptions	Mandatory Services (Minimum Standards of Care)	Other Services
a. Surgery	a.1. Partial mastectomy or lumpectomy a.2. Subcutaneous/Simple/Total mastectomy a.3. Modified Radical Mastectomy a.4. Total Mastectomy with sentinel lymph node biopsy a.5. Partial mastectomy or lumpectomy with sentinel lymph node biopsy a.6. Partial mastectomy or lumpectomy with axillary node dissection a.7. Modified Radical Mastectomy with skin coverage for stage IIIB or above	
b. Diagnostic Tests		CBC with platelet count* Chest X-ray PA and lateral views* Ultrasound (whole abdomen)* ECG Creatinine



Descriptions	Mandatory Services (Minimum Standards of Care)	Other Services
		PT/PTT CP Clearance FBS Urinalysis* 2D echo** Electrolytes:* Sodium Potassium Chloride Calcium Phosphate
c. Medicines		Antimicrobials, as indicated Pain relievers, as indicated
d. Others		Blood support, such as cross-matching, screening, and processing, as needed
Legend:		

- * Not required for Clinical Stage o DCIS ** Not required for HER2 negative breast cancer

Table 3: Surgery Procedures

3. Systemic Therapy: Breast Cancer Treatment Protocols (Annex L)

Treatment Phase	Mandatory Services (Minimum Standards of Care)	Other Services
a. Hormonotherapy	a.1. Tamoxifen ^a (Premenopausal/ postmenopausal)	
	a.2. Anastrozole / Letrozole (Aromatase Inhibitor) (Postmenopausal)	
b. Cytotoxic Chemotherapy ^{b d}	b.1.1. Doxorubicin / Epirubicin (A) b.1.2. Cyclophosphamide (C) b.1.3. Docetaxel (T) b.1.4. Granulocyte colony- stimulating factor (G- CSF)	Antiemetic, as needed Antimicrobials, as indicated Pain relievers, as indicated



Treatment Pliase	Mandatory Services (Minimum Standards of Care)	Other Services
	b.2.1. Doxorubicin / Epirubicin (A) b.2.2. Cyclophosphamide (C) b.2.3. Paclitaxel (Pacli)	Other medicines, as indicated
	b.3.1. Docetaxel (T) b.3.2. Carboplatin AUC (Cb) b.3.3. Granulocyte colony- stimulating factor (G- CSF)	
c. Targeted Therapy	c.1. Trastuzumab (H) ^{ce} c.2. 2D echo every 4th cycle	Granulocyte colony- stimulating factor (G-CSF) Antiemetic, as needed Antimicrobials, as indicated Pain relievers, as indicated Other medicines, as indicated

Legend:

- ^a Tamoxifen is given to premenopausal and postmenopausal women, particularly ER+/PR+/HER2neu- patients. For postmenopausal ER+/PR+/HER2neu+ patients, an aromatase inhibitor is preferred
- ^b Not required for Stage o DCIS
- ^c For Her2-positive breast cancer
- ^d Maximum of two (2) chemotherapy protocol during pre-authorization if the initial chemotherapy regimen cannot be tolerated by the patient
- ^e Each tranche has a maximum of 6 cycles. Maximum of 3 tranches of targeted therapy once in a lifetime

Table 4: Systemic Therapy Protocol

4. Surveillance

Services	Descriptions
a. Basic Services	 a.1. Clinical Consultation a a.2. Chest X-ray b a.3. Mammography of the contralateral breast (if mastectomy) c a.4. Mammography (bilateral, if lumpectomy) c a.5. Ultrasound (whole abdomen d, or breast e)



Services		Descriptions
	a.6.	Gynecological Evaluation and Transvaginal Ultrasound $^{\rm f}$
b. Specific Services	b.2.	2D Echo ^g Bone Densitometry ^h Bone Scan ⁱ

Legend:

- ^a Clinical consultation after completion of treatment, every 3-4 months for 1st 3 years particularly for high risk patients (Stage IIB-IIIC) then once every year if asymptomatic; every month if Stage IV.
- ^b Chest X-ray once a year, as needed
- ^c Can be availed of by patient at post-surgery, maximum of one (1) availment per year, as needed
- ^d Ultrasound of whole abdomen, once a year, if needed
- e Ultrasound of breast, once a year, if needed
- $^{\rm f}$ Gynecological exam and transvaginal ultrasound, once a year if with ongoing treatment of hormonotherapy
- g 2D echo, once a year, after completion of treatment cycle of doxorubicin or trastuzumab, as per cardiology advice
- ^hBone densitometry, once a year if with ongoing treatment of aromatase inhibitor
- i Bone scan, once a year if symptomatic, as needed

Table 5: Surveillance Services

F. Package Codes and Rates

1. Diagnostic Tests and Prognostication

Package Codes	Mandatory Services	Package Rates (PHP)
Z021A1	Diagnostic Tests	
	Mammography, Ultrasound, and Clinical Consultation (Physical Examination and History)	3,500
Z021A2	Diagnostic Tests	
	Mammography Clinical Consultation (Physical Examination and History)	2,500
Z021A3	Diagnostic Tests	
	Ultrasound Clinical Consultation (Physical Examination and History)	1,000



Package Codes	Mandatory Services	Package Rates (PHP)
Z021B	Breast Panel Complete Blood Count with Platelet Count ER/PR Hormone Test Her2/neu Immunohistochemistry (IHC) Test Metabolic Panel with Liver Function Tests Alkaline Phosphatase	10,000
Z021C	Fluorescent in Situ Hybridization (FISH) for Her2/neu amplification	1,400

Table 6: Diagnostic Tests and Prognostication Package Rates and Codes

2. Surgical Procedures

Package Codes		Descriptions	Package
Neoadjuvant	Adjuvant	Descriptions	Rates (PHP)
Z021D1	Z021D2	Partial mastectomy or lumpectomy	30,000
Z021E1	Z021E2	Subcutaneous/ Simple/ Total mastectomy	
Z021F1	Z021F2	Modified Radical Mastectomy	
Z021G1	Z021G2	Partial mastectomy or Lumpectomy with sentinel lymph node biopsy	100,000
Z021H1	Z021H2	Partial mastectomy or Lumpectomy with axillary node dissection	
Z021I1	Z021I2	Total Mastectomy with sentinel lymph node biopsy	
Z021J1	Z021J2	Modified Radical Mastectomy with skin coverage for clinical stage IIIB or above	140,000

Table 7: Surgical Procedures Package Rates and Codes



3. Hormonotherapy

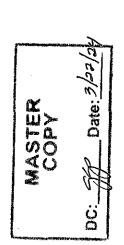
Package Codes	Descriptions	Tranche No:	Package Rate per Tranche (PHP)	Amount per Prescription (PHP)
Z021K1	Tamoxifen (for	1	2,700	450 per
Z021K2	premenopausal / postmenopausal	2	2,700	Monthly Prescription
Z021L1	Anastrozole /	1	18,000	3,000 per
Z021L2	Letrozole (postmenopausal)	2	18,000	Monthly Prescription

Table 8: Hormonotherapy Package Rates and Codes

4. Cytotoxic Chemotherapy

Packag	e Codes			Package	Amount
Neo- adjuvant	Adjuvant	Descriptions	Number of Cycles	Rate (PHP)	per Cycle (PHP)
Z021M11	Z021M21	Doxorubicin/ Epirubicin (A)	AC x 4 cycles	55,000	13,750
Z021M12	Z021M22	Cyclophospha mide (C) + Docetaxel (T)	T x 4 cycles	67,000	16,750
Z021N11	Z021N21	Doxorubicin/ Epirubicin (A)	AC x 4 cycles	43,920	10,980
Z021N12	Z021N22	Cyclophospha mide (C) + Paclitaxel (Pacli)	Pacli x 12 cycles	154,080	12,840
Z021O1	Z021O2	Docetaxel (T) + Carboplatin (Cb)	T + Cb x 6 cycles	185,010	30,835

Table 9: Cytotoxic Chemotherapy Protocol, Package Rates and Codes



5. Targeted Therapy

Package Codes	Descriptions	Package Rate (PHP)	Package Rate per Cycle (PHP)
Z021P1	Trastuzumab (H), Tranche 1	1,000,008 (333,336 per	
Z021P2	Trastuzumab (H), Tranche 2	Tranche, (one tranche is equivalent to 6	55,556
Z021P3	Trastuzumab (H), Tranche 3	cycles) (maximum of 18 cycles)	· · · · · · · · · · · · · · · · · · ·

Table 10. Targeted Therapy Package Rates and Codes

6. Surveillance

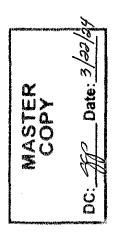
Package Codes	Descriptions	Package Rate (PHP)
	Basic Services	
Z021Q1	Mammography (contralateral if mastectomy or bilateral, if lumpectomy) and Clinical Consultation	2,500
	Ultrasound (Breast) and Clinical Consultation	
Z021Q2	or	1,100
	Ultrasound (Whole Abdomen) and Clinical Consultation	
Z021Q3	Gynecological Evaluation and Transvaginal Ultrasound	1,100
Z021Q4	Chest X-ray 300	
	Specific Services	
Z021R	2D Echo	2,500
Z021S	Bone Densitometry	2,500
Z021T	Bone Scan	4,000

Table 11. Surveillance Package Rates and Codes

G. Filing Schedule

The filing schedule for claims submission are as follows:

Package Codes	Descriptions	Amount (PHP)	Filing Schedule
A. Diagnost	ic Tests and Prognosti	cation	
Z021A1	Diagnostic Tests	3,500	Within 60 days upon completion of the services
Z021A2	Diagnostic Tests	2,500	Within 60 days upon completion of the services
Z021A3	Diagnostic Tests	1,000	Within 60 days upon completion of the services
Z021B	Breast Panel	10,000	Within 60 days upon completion of the services
Z021C	Fluorescent in Situ Hybridization (FISH)	1,400	Within 60 days upon completion of the service
B. Surgery F	rocedures	·	
Z021D1 (Neo- adjuvant) Z021D2 (Adjuvant)	Partial Mastectomy or Lumpectomy	30,000	Within 60 days after discharge from surgery
Zo21E1 (Neo- adjuvant) Zo21E2 (Adjuvant)	Subcutaneous/ Simple / Total Mastectomy	100,000	Within 60 days after discharge from surgery
Zo21F1 (Neo- adjuvant) Zo21F2 (Adjuvant)	Modified Radical Mastectomy	100,000	Within 60 days after discharge from surgery



(Adjuvant)	Node Dissection	
Zo21I1 (Neo- adjuvant) Zo21I2 (Adjuvant)	Total Mastectomy with Sentinel Lymph Node biopsy	100,000
ZO21J1 (Neo- adjuvant) ZO21J2 (Adjuvant)	Modified Radical Mastectomy with skin coverage for IIIB and above	140,000
C. Hormone	otherapy	
Package Codes	Descriptions	Amount (PHP)
Z021K1	Tamoxifen; Tranche 1 (Premenopausal/ Postmenopausal)	2,700 (450 per Monthly Prescription)
Z021K2	Tamoxifen; Tranche 2 (Premenopausal/ Postmenopausal)	2,700 (450 per Monthly

Postmenopausal)

Descriptions

Mastectomy or

Sentinel Lymph

Mastectomy or

Lumpectomy

with Axillary

Node Biopsy

Lumpectomy with

Partial

Partial

Amount (PHP)

100,000

100,000

Prescription)

Filing Schedule

Within 60 days

after discharge

from surgery

Within 60 days

after discharge

from surgery

Within 60 days after discharge from surgery

Within 60 days after discharge from surgery

Filing schedule

Within 60 days after the 6th Month Prescription

Within 60 days after the 12th Month

Prescription

Package

Codes Z021G1

(Neo-

adjuvant)

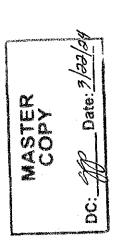
Z021G2

(Adjuvant) Z021H1

(Neo-

adjuvant)

Z021H2



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	_ (Date: 3/0	

Package Codes	Descriptions	Amount (PHP)	Filing Schedule
Z021L1	Anastrozole / Letrozole Tranche 1 (Postmenopausal)	18,000 (3,000 per Monthly Prescription)	Within 60 days after the 6th Month Prescription
Z021L2	Anastrozole / Letrozole Tranche 2 (Postmenopausal)	18,000 (3,000 per Monthly Prescription)	Within 60 days after the 12th Month Prescription
D. Cytotoxic	Chemotherapy		
Zo21M11 (Neo- adjuvant)		(AC) 55,000 (13,750 rate cycle,	
Zo21M21 (Adjuvant)	Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C) + Docetaxel	maximum of 4 cycles)	Within 60 days upon the completion of the
Z021M12 (Neo- adjuvant)	(T)	(T) 67,000 (16,750 rate	last cycle
Zo21M22 (Adjuvant)		cycle, maximum of 4 cycles)	
Zo21N11 (Neo- adjuvant)		(AC) 43,920 (10,980 rate cycle,	
Z0021N12 (Adjuvant)	Doxorubicin/	maximum of 4 cycles)	Within 60 days
Zo21N21 (Neo- adjuvant)	Epirubicin (A) + Cyclophosphamide (C) + Paclitaxel (Pacli)	(Pacli) upon completion	upon the completion of the last cycle
Zo21N22 (Adjuvant)		cycle, maximum of 12 cycles)	

Codes			
Zo21O1 (Neo- adjuvant) Zo21O2 (Adjuvant)	Docetaxel (T) + Carboplatin (Cb)	185,010 (30,835 rate cycle, maximum of 6 cycles)	Within 60 days upon the completion of the last cycle
E. Targeted	d Therapy		
Z021P1	Trastuzumab (H), Tranche 1	1,000,008 (333,336 per tranche,	Within 60 days after the completion of 6th cycle
Z021P2	Trastuzumab (H), Tranche 2	one tranche is equivalent to 6 cycles)	Within 60 days after the completion of 12th cycle
Z021P3	Trastuzumab (H), Tranche 3	(55,556, rate cycle, maximum of 18 cycles)	Within 60 days after the completion of 18th cycle
F. Surveilla			
Z021Q1	Surveillance, Basic Services	2,500	Within 60 days upon completion of the services
Z021Q2	Surveillance, Basic Services	1,100	Within 60 days upon completion of the services
Z021Q3	Surveillance, Basic Services	1,100	Within 60 days upon completion of the services
Z021Q4	Surveillance, Basic Services	300	Within 60 days upon completion of the services
Z021R	Surveillance, 2D Echo	2,500	Within 60 days upon completion of the services
Z021S	Surveillance, Bone Densitometry	2,500	Within 60 days upon completion of the services
Z021T	Surveillance, Bone Scan	4,000	Within 60 days upon completion of the services
FF 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7			

MASTER COPY DC: 3/02/24 Package Codes

Descriptions

Amount (PHP)

Table 12. Filing Schedule of the Z Benefits package for Breast Cancer

Filing Schedule

H. Claims Filing

- 1. The contracted HFs shall render all the mandatory services required for a treatment phase or service given to a patient, including other services if necessary.
- 2. There shall be NO direct filing of claims by the members/dependents. All Z Benefits claims shall be filed by the contracted HF.
- 3. The contracted HF shall be responsible for the accuracy, adherence to the guidelines, and efficient handling of all claims filed on behalf of the patients. All required documents, forms, and attachments should be properly filled out before claims filing. The contracted HFs shall submit the complete requirements for claims submission, including its attachment as required per treatment phase or service.
- 4. If the patient is declared lost to follow-up or death, the contracted HF shall file the claims per treatment phase or services given to the patient.
- 5. In cases of changes in the chemotherapy treatment protocol, the corresponding claims forms per treatment protocol shall be accomplished separately and filed simultaneously in accordance with the filing schedule in Table 12.
- 6. The MDT or attending PhilHealth-accredited physicians shall affix their signature to attest that all the mandatory services for a specific treatment phase were rendered to the patient in the corresponding document for reimbursement of claims.
- 7. Contracted HF should strictly monitor patients enrolled in the Z Benefits. The Z Benefits shall not cover any additional services availed of by patients outside the treatment protocol.
- 8. The contracted HFs shall properly indicate the OOP and/or co-payment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption Benefits" and in the Statement of Account (SOA).
- 9. The contracted HFs shall follow the existing guidelines of the SOA⁸ requirement for claims submission under the Z Benefits.
- 10. Contracted HF shall follow all relevant laws, such as, but not limited to, Republic Act (RA) No. 9994 [Expanded Senior Citizens Act of 2010], as amended and RA No. 10754 [An Act Expanding the Benefits and Privileges of Persons with Disability(PWD)], including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on Joint Administrative Order No. 2020-0001, entitled: Operational Guidelines for the Implementation of the



⁸ PhilHealth Circular No. 2022-0024: Statement Of Account (SOA) Requirement For Z Benefit Claims Submission

Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients, pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019."

- 11. The contracted HFs shall follow the filing schedule set by PhilHealth under the Z Benefits for breast cancers for each treatment phase or service.
- 12. The contracted HF shall exhaust efforts to contact, navigate, or obtain information about the whereabouts or situation of their enrolled patients in the Z Benefits. In case of patients who are declared lost of follow-up or when the patient expires, the contracted HFs shall file claims based on the applicable scenarios:
 - a. The contracted HF shall submit to PhilHealth a notarized sworn declaration that the patient is declared lost to follow-up. The contracted HF shall submit their claims within thirty (30) days from such declaration.
 - b. If the patient expires during treatment, the contracted HF shall submit a photocopy of the death certificate or a notarized sworn declaration issued by the authorized government agencies as an attachment to the claims. The contracted HF shall submit their claims within thirty (30) days from the receipt of the death certificate or notarized sworn declaration issued by the authorized government agencies.
- 13. The contracted HF shall submit to PhilHealth the "Breast Cancer Medical Records Summary Form" (Annex M) for all deaths and lost to follow-up patients and Outcome Indicators for Breast Cancer (Annex N).
- 14. The contracted HFs are required to submit the following documents according to the services or treatment phases:
 - a. Diagnostic Tests and Prognostication:
 - a.1. Photocopy of completely accomplished Eligibility Criteria for Diagnostic Test and Prognostication Breast Cancer (Annex A.1)
 - a.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
 - a.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
 - a.4. Checklist of Mandatory and Other Services for Diagnostics and Prognostication (Annex C.1))
 - a.5. Completed Z Satisfaction Questionnaire (Annex D)
 - a.6. Checklist of Requirements for Reimbursement for Diagnostic Test and Prognostication (Annex E.1)
 - a.7. Transmittal Form (Annex H)
 - a.8. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent



b. Surgery:

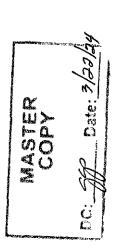
- b.1. Pre-authorization Checklist and Request (Annex A.2)
- b.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
- b.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
- b.4. Photocopy of Member Empowerment Form (Annex B)
- b.5. Checklist of Mandatory and Other Services for Surgery (Annex C.2)
- b.6. Z Satisfaction Questionnaire (Annex D)
- b.7. Checklist of Requirements for Reimbursement Surgery (Annex E.2)
- b.8. Transmittal Form (Annex H)
- b.9. Photocopy of Multidisciplinary Interdisciplinary Team (MDT)
- b.10. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent
- b.11. Photocopy of Accomplished Surgical Operative Report
- b.12. Photocopy of Accomplished Anesthesia Report
- b.13. Photocopy of Histopathology Report

c. Chemotherapy:

- c.1. Pre-authorization Checklist and Request (Annex A.2)
- c.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
- c.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
- c.4. Photocopy of Member Empowerment Form (Annex B)
- c.5. Checklist of Mandatory and Other Services for Chemotherapy (Annex C.3)
- c.6. Z Satisfaction Questionnaire (Annex D)
- c.7. Checklist of Requirements for Reimbursement Chemotherapy (Annex E.3)
- c.8. Breast Cancer Treatment Passport (Annex F)
- c.9. Transmittal Form (Annex H)
- c.10. Photocopy of Multidisciplinary Interdisciplinary Team (MDT) Plan
- c.11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

d. Hormonotherapy:

- d.1. Pre-authorization Checklist and Request (Annex A.2)
- d.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
- d.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
- d.4. Photocopy of Member Empowerment Form (Annex B)



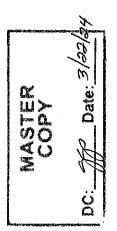
- d.5. Checklist of Mandatory and Other Services for Hormonotherapy (Tranche 1 Annex C.4.1); (Tranche 2 Annex C.4.2)
- d.6. Z Satisfaction Questionnaire (Annex D)
- d.7. Checklist of Requirements for Reimbursement –
 Hormonotherapy (Tranche 1 Annex E.4.1); (Tranche 2 Annex E.4.2)
- d.8. Breast Cancer Treatment Passport (Annex F)
- d.9. Transmittal Form (Annex H)
- d.10. Photocopy of the Multidisciplinary–Interdisciplinary Team (MDT) Plan
- d.11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

e. Targeted Therapy

- e.1. Pre-authorization Checklist and Request (Annex A.2)
- e.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
- e.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
- e.4. Photocopy of Member Empowerment Form (Annex B)
- e.5. Checklist of Mandatory and Other Services for Targeted Therapy (Tranche 1 Annex C.5.1); (Tranche 2 Annex C.5.2); (Tranche 3 Annex C.5.3)
- e.6. Z Satisfaction Questionnaire (Annex D)
- e.7. Checklist of Requirements for Reimbursement Targeted Therapy (Tranche 1 Annex E.5.1); (Tranche 2 Annex E.5.2); (Tranche 3 Annex E.5.3)
- e.8. Breast Cancer Treatment Passport (Annex F)
- e.9. Transmittal Form (Annex H)
- e.10. Photocopy of the Multidisciplinary—Interdisciplinary Team (MDT) Plan
- e.11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent

f. Surveillance:

- f.1. Pre-authorization Checklist and Request (Annex A.2)
- f.2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)
- f.3. Photocopy of Properly Accomplished PhilHealth Claim Form 2 (CF2)
- f.4. Photocopy of Member Empowerment Form (Annex B)
- f.5. Checklist of Mandatory and Other Services for Surveillance (Annex C.6)
- f.6. Z Satisfaction Questionnaire (Annex D)
- f.7. Checklist of Requirements for Reimbursement Surveillance (Annex E.6)
- f.8. Transmittal Form (Annex H)
- f.9. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent



- 15. The Z Satisfaction Questionnaire (Annex D) shall be administered to all patients enrolled in Z Benefits prior to final discharge disposition from the contracted HF per services or treatment phase. These are validated during field monitoring by PhilHealth and shall be used as the basis of the Corporation for benefits enhancement, policy research and quality improvement purposes.
- 16. Existing rules or guidelines on late filing shall apply.
- 17. 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.

I. Claims Evaluation and Payment

- 1. PhilHealth shall have the right to subject any or all claims to medical review before and/or after payment or reimbursement of the contracted HFs, following the existing guidelines.
- 2. The policy on Return to Sender (RTS) shall not apply for the Z Benefits Packages. PhilHealth shall review and determine the completeness of all forms submitted by the contracted HFs. The PROs and LHIOs shall have the prerogative not to accept incomplete documents. However, they should directly coordinate with the contracted HFs regarding the deficiencies in the documents submitted. Once the documents are complete, the contracted HF shall submit these to PhilHealth for payment of claims within the required filing schedule.
- 3. PhilHealth shall reimburse the contracted HFs based on the predetermined package rates or case-based payment set for each service or treatment phase covered by the Z Benefits package, except for targeted therapy. Reimbursement for targeted therapy shall be based on the actual amount as reflected in the SOA or its equivalent, not to exceed the amount per cycle as indicated in Table 10.
- 4. When the patient expires or is declared lost to follow-up, PhilHealth shall only reimburse the corresponding amount of the benefit package based on the number of cycles or sessions, prescriptions, or services rendered by the contracted HF.
- 5. Claims for the applicable treatment phase or service for breast cancer within the same period shall not be considered overlapping claims.
- 6. Any change of member/patient category upon approval of the preauthorization shall not affect the benefit availment.
- 7. Any amount declared in the SOA that are below or above the package rates shall not be interpreted as over or underpayment. All rates are considered inclusive of government taxes or net of mandatory discounts, as applicable.



- 8. PhilHealth shall process all claims submitted by the contracted HFs within thirty (30) working days upon receipt of claims applications, provided that the mandatory documents and attachments are complied with.
- 9. Claims filed by the contracted HF shall be denied based on the following instances:
 - a. If a mandatory service was not provided by the contracted HF;
 - b. If the required signatures in the forms are missing in the documents submitted:
 - c. Improperly filled-out forms;
 - d. Late filing;
 - e. Incomplete attachments.
- The contracted HF may apply for a motion for reconsideration (MR) for all denied Z Benefits claims based on existing PhilHealth policies.
- 11. Rules on pooling professional fees for government facilities shall apply. There will be no differentiation between facility and professional fees (PF). Payments shall be credited on the accounts of the contracted health facilities. It is the sole responsibility of the contracted HF to distribute the PF to their health professionals based on their mutual agreements and internal processes prior to contracting.

J. Monitoring

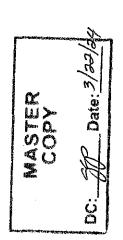
PhilHealth shall enforce current policies and guidelines on monitoring the performance of the contracted HFs in its policy implementation of the Z Benefits package for Breast Cancer and establish strict control mechanisms to prevent adverse provider behaviors and fraud detection.

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

The Corporation shall establish the performance indicators and outcome measures to monitor compliance with the policies of this Circular and the general treatment algorithm in collaboration with relevant stakeholders and experts and incorporate the indicators into the relevant monitoring policies.

K. Policy Review

PhilHealth shall conduct a regular policy review of the Z Benefits for Breast Cancer in consultation and collaboration with relevant stakeholders, experts, and technical staff representatives from the Corporation.



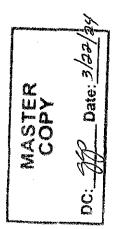
L. Marketing and Promotion

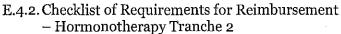
PhilHealth shall conduct communication and social marketing activities to educate the general public and increase their awareness of Z Benefits and to promote informed decision-making and participation among patients, healthcare professionals, healthcare providers, and other stakeholders, including marketing and promotional activities shall be undertaken following the Integrated Marketing and Communication Plan of PhilHealth.

M. List of Annexes (Posted on Official PhilHealth Website)

- Annex A.1: Checklist of Eligibility Criteria for Diagnostic Tests and Prognostication – Breast Cancer
- 2. Annex A.2: Pre-authorization Checklist and Request Form
- 3. Annex B: Member Empowerment (ME) Form
- Annex C: Checklist of Mandatory or Other Services
 - C.1. Checklist of Mandatory and Other Services for Diagnostics and Prognostication
 - C.2. Checklist of Mandatory and Other Services for Surgery
 - C.3. Checklist of Mandatory and Other Services for Chemotherapy
 - C.4.1. Checklist of Mandatory and Other Services for Hormonotherapy Tranche 1
 - C.4.2. Checklist of Mandatory and Other Services for Hormonotherapy Tranche 2
 - C.5.1. Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 1
 - C.5.2. Checklist of Mandatory and Other Services for Targeted Therapy Tranche 2
 - C.5.3. Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 3
 - C.6. Checklist of Mandatory and Other Services for Surveillance
- Annex D: Z Satisfaction Questionnaire
- 6. Annex E: Checklist of Requirements for Reimbursement
 - E.1. Checklist of Requirements for Reimbursement Diagnostic Tests and Prognostication
 - E.2. Checklist of Requirements for Reimbursement –
 - E.3. Checklist of Requirements for Reimbursement Chemotherapy
 - E.4.1. Checklist of Requirements for Reimbursement

 Hormonotherapy Tranche 1





E.5.1. Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 1

E.5.2. Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 2

E.5.3. Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 3

E.6. Checklist of Requirements for Reimbursement – Surveillance

7. Annex F: Breast Cancer Treatment Passport

8. Annex G: Checklist for Patient Transfer

9. Annex H: Transmittal Form

10. Annex I: Letter of Intent for Transfer to a Contracted Health Facility

11. Annex J: Sample Claim Form (CF) 2

J.1. Diagnostic Tests or Prognostication

J.2. Surgery

J.3. Cytotoxic Chemotherapy

J.4.1. Hormonotherapy Tranche 1

J.4.2. Hormonotherapy Tranche 2

J.5.1. Targeted Therapy Tranche 1

J.5.2. Targeted Therapy Tranche 2

J.5.3. Targeted Therapy Tranche 3

J.6. Surveillance

12. Annex K: Pathway of the Benefits Availment of Z Benefits for Breast

Cancer

13. Annex L: Breast Cancer Treatment Protocols

14. Annex M: Breast Cancer Medical Records Summary Form

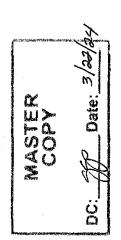
15. Annex N: Outcome Indicators

16. Annex O: Guide on Co-payment Proposal of the Z Benefits Package for

Breast Cancer

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of RA No. 7875, as amended by RA Nos. 9241, 10606, and RA No. 11223, and their respective Implementing Rules and Regulations, 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 forms specified in this policy on the PhilHealth website and the deployment of necessary enhancements in the claims system.
- B. Once the ZBITS module for pre-authorization is functional, the contracted HF shall process the Pre-authorization Checklist and Request through the HCI portal and attach the required documents, such as ME Form and the MDT plan. In addition, PhilHealth will generate a unique case number for every pre-authorization request submitted once the pre-authorization system is developed and fully functioning. In the meantime, the contracted HF may assign a case number for tracking purposes.
- C. The contracted HF shall submit a new pre-authorization request to the PRO for patients with approved pre-authorization but have not initiated any treatment under the previous policy.
- D. Claims for surgical procedures with approved pre-authorization date prior to the effectivity of this PhilHealth Circular shall follow the rules on claims processing as outlined in PC No. 2021-0022 "The Guiding Principles of the Z Benefits (Revision 1). The contracted HF may submit a new pre-authorization request for the continuation of other treatments and services provided under this policy.
- E. Breast cancer patients currently enrolled under the Z Benefits and undergoing treatment for chemotherapy shall be processed and completed according to the guidelines for claims processing and requirements for claims submission provided in PC No. 2021-0022.

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 specific provisions on PhilHealth Circular (PC) No. 030 s. 2012 entitled "Case Type Z Benefit Package For Acute Lymphocytic (Lymphoblastic) Leukemia (ALL), Breast Cancer, Prostate Cancer And Kidney Transplant" and PC No. 2021-0022 entitled "The Guiding Principles of the Z Benefits (Revision 1)" relevant to Z Benefits Package for Breast Cancer.

All PhilHealth Circulars, issuances, rules, and regulations or part thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

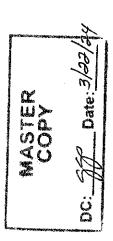


X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on March 30, 2024 following the completion of its publication in the Official Gazette or any newspaper of general circulation. Three (3) certified copies shall be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

EMMANUTIAR. LEDESMA, JR. President and Chief Executive Officer

Date signed: 13 20 2024



Annex A.1: Checklist of Eligibility Criteria for Diagnostic Tests and Prognostication – Breast Cancer





Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

- Citystate Centre, 709 Shaw Boulevard, Pasig City
- **६** (02) 8662-2588 ⊕ www.philhealth.gov.ph
- PhilHealthOfficial X teamphilhealth

Case No		
HEALTH FAC	ILITY (HF)	
ADDRESS OF	HF	
A. PATIENT	1. Last Name, First Name, Mide	lle Name, Suffix SEX ☐ Male ☐ Female
de ha antr Marijusa	2. PhilHealth ID Number	
B. MEMBER	(Answer only if the patient "same as above") 1. Last Name, First Name, Mid	is a dependent; otherwise, write, dle Name, Suffix
et gesenher obbedsom 19 20 de milion dipole dibon estas di	2. PhilHealth ID Number	
	f Eligibility Criteria for Diag Breast Co the status column if YES or write	
Tado a () III	Eligibility Criteria	Status
1. Positive (+) breast mass; AND/OR	
2. Palpable a	illary lymph node	
3. BI-RADS Place a (✓) in ☐ Categor ☐ Categor	the appropriate tick box Y 4	
4. Biopsy res	ults (malignant breast cancer)	
5. Immunohi	stochemistry (IHC) result 2+ a	
6. HER2 stat	us results is not clear or equivoc	al a
^a Required for prantition	ocedures requiring Fluorescent in situ	hybridization (FISH) for Her2/Neu
Certified Corr	ect by:	Conforme by:
	ed name and signature) ttending Physician	(Printed name and signature) Patient
PhilHealth Accreditation No. Date signed (1		Date signed (mm/dd/yyyy)





Annex A.2: Pre-authorization **Checklist and Request Form**





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

○ Citystate Centre, 709 Shaw Boulevard, Pasig City

• (02) 8662-2588 ⊕ www.philhealth.gov.ph

☐ PhilHealthOfficial X teamphilhealth

		Case No	
	-	HEALTH FAC	ILITY (HF)
		ADDRESS OF	HF
		A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX ☐ Male ☐ Female
		der Schrödenb Besternen ber	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
		PLANTER MINISTER	2. PhilHealth ID Number - III-IIIIIIIIIIIIIIIIIIIIIIIIIIIIIII
			(Place a ✓opposite appropriate answer)
		History of P	revious Treatment Not Applicable Last Session or Cycles (mm/dd/yyyy)
		Surgery (S	pecify Site):
		Hormonal	
			Chemotherapy
		☐ Targeted T	herapy umber of Cycles Provided):
		(Specify 2)	
			(Place a vopposite appropriate answer)
		Menstrual S	
		☐ Pre-menop	
		HER2 Status	***************************************
	_	\square 0 – 1+ (HE	R2 Negative) 2+ (Borderline) 3+ (HER2 Positive)
and the state of t	assaring gramme		(Place a ✓ opposite appropriate answer)
	22	Right	Laterality and Clinical Staging ^a
	3/	-	
X	a)	CStage O CStage IA	
H o	ă	CStage IB	cStage IB
S		☐ cStage IIA	I
4 0	8	Stage IIB	
40 2	12 m	CStage IIL	
		CStage IIII	
	ä	CStage IIIC	I — 3
CAN STREET, MANAGEMENT OF THE STREET,		☐ cStage IV	☐ cStage IV
		a If hilateral tick	in the appropriate box both laterality and its corresponding clinical staging



(Place a ✓opposite appropriate answer) **Applicable Treatment Protocol** Surgery Adjuvant Neoadjuvant Hormonal Therapy 🔲 Adjuvant 🔲 Neoadjuvant Protocol: 🔲 Doxorubicin (A) 🐇 Cyclophosphamide (C) + Docetaxel (T) Cytotoxic Chemotherapy \square Doxorubicin (A) +Cyclophosphamide (C) + Paclitaxel (Pacli) Docetaxel (T) + Carboplatin (Cb) If with previous targeted therapy ☐ Targeted Therapy Specify number of cycles to be provided: _ ☐ Surveillance

MASTER COPY DC: M Date: 3/33

HEALTH FAC	HEALTH FACILITY (HF)						
ADDRESS OF	HF						
A.PATIENT	1. Last Name, First Name, Mide	dle Name, Suffix	SEX □ Male □ Female				
	2. PhilHealth ID Number		<u> </u>				
B. MEMBER	"same as above")		otherwise, write,				
	2. PhilHealth ID Number						
Attending Me Oncologist: Printed Name PhilHealth Ac Certified Corr	and Signature creditation No.	Surgeon: Printed Name	and Signature creditation No.				
PhilHealth Additional PhilHealth	ed, the contracted HF shall print signed by the patient, parent of This form shall be submitted PhilHealth Regional Office (PF) eed to attach laboratory results. The PhilHealth Regional Office where and may be checked during	Date Signed (recover) The approved pre-arguardian and heal to the Local Health (RO) when filing the feature of the three shoots are the second to the Local Health (RO) when filing the feature of the second to the Local Health (RO) when filing the feature of the second to the Local Health (RO) when filing the feature of the second to the local However, these shows the second to the local However, these shows the local However, the	uthorization form th care providers, Insurance Office first tranche.				
	ADDRESS OF A. PATIENT B. MEMBER Attending Med Oncologist: Printed Name PhilHealth Actending Ractor Oncologist: Printed Name PhilHealth Actending Ractor Oncologist: Note: Once approve and have this as applicable (LHIO) or the There is no near the patient's content of the patient's content o	ADDRESS OF HF A. PATIENT 1. Last Name, First Name, Mide 2. PhilHealth ID Number B. MEMBER (Answer only if the patient "same as above") 1. Last Name, First Name, Mide 2. PhilHealth ID Number Certified Correct by Attending Medical Oncologist: Printed Name and Signature PhilHealth Accreditation No. Certified Correct by Attending Radiologic Oncologist: Printed Name and Signature PhilHealth Accreditation No. Note: Once approved, the contracted HF shall print and have this signed by the patient, parent o as applicable. This form shall be submitted (LHIO) or the PhilHealth Regional Office (PF There is no need to attach laboratory results.	ADDRESS OF HF A. PATIENT 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number B. MEMBER (Answer only if the patient is a dependent: "same as above") 1. Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number Certified Correct by Attending Medical Oncologist: Printed Name and Signature PhilHealth Accreditation No. Printed Name and Signature PhilHealth Accreditation No. Printed Name and Signature PhilHealth Accreditation No. Date Signed (r Note: Once approved, the contracted HF shall print the approved preaand have this signed by the patient, parent or guardian and heal as applicable. This form shall be submitted to the Local Health (LHIO) or the PhilHealth Regional Office (PRO) when filing the field monitoring the patient's chart and may be checked during the field monitoring				

PRE-AUTHORIZATION REQUEST Breast Cancer

	DA	DATE OF REQUEST (mm/dd/yyyy):										
	Th	This is to request approval for provision of services under the Z benefit package for										
	(P	in										
under the terms and conditions as agreed for availment of the Z Benefit Package.												
	pa □	ne patient is aware of the ckage (please tick appro Without co-payment With co-payment, for th	priate be)х):	cy on co-payment and agree	ed to avail o	the benefit					
	Ce	rtified Correct by:			Certified Correct by:							
		(Printed Name a Attending Medic			(Printed Na	me and Sig ding Surgeo						
		ilHealth creditation No.			PhilHealth Accreditation No.							
	Ce	rtified Correct by:			Certified Correct by:	<u>i. u</u>						
		(Printed Name an Attending Radiolog	d Signat ic Oncol	ure) ogist	(Printed Name and Signature) Executive Director/Chief of Hospital/							
					Medical Director							
		ilHealth creditation No.			PhilHealth Accreditation No.							
SENENHER I	na Gar	na kanang			Conforme by:							
•	3/25/6	era			(Printed Na	me and Sign Patient	nature)					
п	Date: 3/			(For Pi	nilHealth Use Only)	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~						
 N	ä.		74 - 4		mireum esc omy)							
, 	G,	□ DISAPPROVED (S	State reas	son/s)_	HARLE BY POST AND FRAME FRAME	 						
	1	(Printed name an				(7) (8)						
	() ()	<u></u>		tative, E	Benefits Administration Sec							
CONTRACTOR	Reins Reference	INITIAL APPLIC	CATION Initial	Date	COMPLIANCE TO I ☐ APPROVED	KEQUIKEV	MENTS					
		Received by	IIIIII	Date	☐ DISAPPROVED (State rea	ason/s)						
		LHIO/BAS:			(D.1 t 1							
		Endorsed to BAS (if received by LHIO):			(Printed name a Head or authorized I							
		□Approved □Disapproved			Activity	Initial	Date					
		Released to HF:			Received by BAS:							
		The pre-authorization	ı for		☐ Approved ☐ Disapproved							
		chemotherapy (neoad	ljuvant)									
		surgery (adjuvant) sh for 60 calendar days.	ali be va	lid	Released to HF:							

Annex B: Member Empowerment Form





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

- Citystate Centre, 709 Shaw Boulevard, Pasig City
- PhilHealthOfficial X teamphilhealth

Numero ng kaso: Case No.

MEMBER EMPOWERMENT FORM

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

Mga Panuto: Instructions:

- 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.
- 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 (\checkmark) .
- 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.
- Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form. The ME form shall be reproduced by the contracted health facility (HF) providing specialized
- 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.
- 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 ZBenefits, write N/A for items B2 and B3.

Date:

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 no	ame, Suffix)								
NUMERO NG PHILHEALTH ID NG PASYE	NTE 🗆 🗆 🗆 🗆 🗆 [
PHILHEALTH ID NUMBER OF PATIENT MIYEMBRO (kung ang pasyente ay kalip	fleedown weldingleone (Anal	de Borrelon Borreitana Archido							
Karagdagan sa Pangalan) MEMBER (if patient is a dependent) (Last n									
NUMERO NG PHILHEALTH ID NG MIYEM	1BRO 🗆 🗕 🗆 🗆 🗆	000000 - 00							
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	☐ Kasambaha	y / Household Help							
Employed private Empleado ng gobyerno		o ng Pamilya/ <i>Family driver</i> Manggagawa sa ibang bansa							
Employed government		orker/OFW							
☐ May sariling pinagkakakitaan	□ Land-ba								
Self-earning ☐ Indibidwal	Land-be	ased Sea-based ay na kaanib/ Lifetime Member							
Individual		may dalawang							
☐ Sole proprietor	pagkamam	amayan/Nakatira sa ibang bansa							
Sole proprietor		th Dual Citizenship/Living abroad							
☐ Group enrollment scheme Group enrollment scheme	□ Foreign na	tional/Foreign national							
		······································							
Indirect contributor Indirect contributor									
☐ Listahanan	□ Inisponsura	ın ng LGU							
Listahanan	LGŪ-spons								
□ 4Ps/MCCT	☐ Inisponsur NGA- <i>spon</i> s								
4Ps /MCCT ☐ Nakatatandang mamamayan		orea an ng pribadong sector							
Senior Citizen (RA 10645)	Private-sp								
□ PAMANA	☐ Taong may	kapansanan							
PAMANA □ KIA/KIPO	Person wit	h disability							
KIA/KIPO									
☐ Bangsamoro/Normalization									
Iba pa									
Others	aanabla								
☐ Point of Service (POS) Financially In	capable								

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		Impormasyong Klinikal	
		Clinical Information	
ſ	1.	Paglalarawan ng kondisyon ng	
		pasyente	
		Description of condition	
t		Napagkasunduang angkop na plano	
		ng gamutan sa ospital	
		Applicable Treatment Plan agreed	
1		upon with healthcare provider	
ŀ			
		Napagkasunduang angkop na	
		alternatibong plano ng gamutan sa	
		ospital	
		Applicable alternative Treatment	
		Plan agreed upon with health care	•
L		provider	
	C.	Talatakdaan ng Gamutan at Kasu	nod na Konsultasyon
1		Treatment Schedule and Follo	
	1.	Petsa ng unang pagkakaospital o	
1		konsultasyon a	
		(buwan/araw/taon)	
		Date of initial admission to HF or	
-			
		consult ^a (mm/dd/yyyy)	
Ì		B Days on 7MOPDU / man hatana man	
		Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa pagkonsulta	
-		para sa rehabilitasyon ng external lower limb	
١		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	
'n		pagsasayos ng device. Para naman sa PD First,	
No.		ito ay ang kasunod na pagbisita sa PD Provider.	
		b For ZMORPH/CWDS, this refers to the measurement, fitting and adjustments of the	
100		device. For the PD First, this refers to the next	
		visit to the PD Provider.	
ĺ	L		
	3.	Pansamantalang Petsa ng kasunod	
į	-	na pagbisita ^c (buwan/araw/taon)	
		Tentative Date/s of follow-up	
ě		visit/s c (mm/dd/yyyy)	
1		Para sa ZMORPH/ mga batang may	
		kapansanan, ito ay tumutukoy sa rehabilitasyon	
Appropries		ng external lower limb post-prosthesis.	
		 For ZMORPH/CWD, this refers to the external lower limb post-prosthesis 	
ŀ		rehabilitation consult.	

). Edukasyon ng Miyembro). Member Education		· · · · · · · · · · · · · · · · · · ·
]	agyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol int a check mark (√) opposite appropriate answer or NA if not applicable.	OO YES	HINDI NO
	Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. My health care provider explained the nature of my condition/disability.		
2	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.		·
And the second s	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.		

200 E 200 E

Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol Put a check mark(√) opposite appropriate answer or NA if not applicable.	OO YES	HINDI NO
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. My health care provider gave me the schedule/s of my follow-up visit/s.	I, IMO	NO ,
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.		
The "no balance billing" (NBB) policy was explained to me. Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC).		
Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e.		

	For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e.		
	c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses	·	
	d. Sakaling ako ay 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		
44-	* 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.		
	* Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy.		

For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy. 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. * Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy. For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy. 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.



	Tungkulin at Responsabilidad ng Miyembro Member Roles and Responsibilities		
Li	gyan ng (√) ang angkop na sagot o NA kung hindi nauukol	- 00	HINDI
	at a (\checkmark) opposite appropriate answer or NA if not applicable.	YES	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 Pets F. Printed Name, Signature, Thumb Pri		
Pangalan at Lagda ng pasyente:* Printed name and signature of patient*	Petsa (buwan/ araw/ taon)	
*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.	(if patient is unable to write)	
Pangalan at lagda ng nangangalagang Doktor: Printed name and signature of Attending Doc	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 mem	Petsa (buwan/araw/taon) Date (mm/dd/yyyy)	
Pangalan at lagda ng asawa/ magulang / pina kamag-anak/awtorisadong kinatawan Printed name and signature of spouse/ parer /authorized guardian or representative walang kasama/ no companion	Petsa (buwan/araw/taon) Date (mm/dd/yyyy)	

G. <i>G</i> .	Detalye i PhilHea	ng Tagapag-ug Ith Z Coordina	nay ng Phil tor Contac	Healt t Deta	h para iils	sa Z be	nefits	
Par	ngalan ng	Tagapag-ugnay r Health Z Coordi	ig PhilHealth	para s	a Z ben	efits na	nakatala	ga sa ospital
	Numero ng Telepono Telephone number Numero ng Cel Mobile number						Email A	ddress
H.	PhilHea	ng maaaring ta Ith Contact De nrehiyon ng Phil	tails	PhilHo	ealth		-	
Phi Nu		egional Office No						
pas	syente	sa pagsusuri sa l lo access patie				nefit inf		ay ang <i>medical data</i> n and tracking system
					Z bene	fit info	rmatio	nedical data in the on & tracking
aki ang I co mg	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 System (ZBITS) Ako ay pumapayag na mailagay ang aking impormasyong medikal sa ZBITS na kailangan sa Z benefits. Pinahihintulutan din ang PhilHealth na maipaalam ang aking personal na impormasyong pangkalusuga mga kinontratang ospital.						sa ZBITS na Pinahihintulutan ko naipaalam ang aking ong pangkalusugan sa	
					electron for the disclose	nically i Z Benef e my pe	in the ZB its. I aut	edical data entered ITS as a requirement horize PhilHealth to ealth information to
kir	ıatawan n	apatunay na wala lula sa pahintulo gamit ng Z benef	t na nakasaa	d sa ita	g PhilH	ealth o	sinuman	g opisyal, empleyado o ko itong ibinigay
an wi	y and all i llingly giv	iabilities relative en in connection	e to the herei with the Z c	n-men	tioned c	onsent i urseme	which I h nt before	
Pr	Buong pangalan at lagda ng pasyente* Printed name and signature of patient* Thumb print (Kung hindi na makasusulat) Date (mm/dd/yyyy)						(buwan/araw/taon)	
* F thu	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. (if patient is unable to write)							
Pr	rinted narr	alan at lagda ng k ne <i>and signature</i> ama <i>/ no compani</i> o	of patient's 1	_	-			Petsa (buwan/araw/taon) Date (mm/dd/yyyy)
Re	elasyon ng	kumakatawan sa of representation	a pasyente (La					<u> </u>
1 1	asawa spouse	□ magulang parent	\square anak $child$	□ kap	atid t of kin	□tagap guare	ag-alaga <i>lian</i>	□ walang kasama no companion

Annex C.1: Checklist of Mandatory and Other Services for Diagnostics





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Case No.	

CHECKLIST OF MANDATORY AND OTHER SERVICES

	Breast Cancer - Diagnostic	es and Prognosuca	uon .			
HEALTH FAC	ILITY (HF)					
ADDRESS OF	HF					
A. PATIENT	1. Last Name, First Name, Mide		SEX □ Male □ Female			
nie Corto podpilaje post program i podpilaje	2. PhilHealth ID Number					
B. MEMBER Ultrasound	(Answer only if the patient "same as above") 1. Last Name, First Name, Midd 2. PhilHealth ID Number MANDATORY Diagnost	lle Name, Suffix Place a (/) in the a SERVICES ic Test				
AND/OR						
Mammog	aphy	Date of procedure (mm/dd/yyyy):				
	nsultation	Date of consultati	on (mm/dd/yyyy):			
	Breast I	Panel				
G 1	rmone Test	Date of procedur	e (mm/dd/yyyy):			
Her2/neu (IHC) testi	Immunohistochemistry ng	Date of procedur	re (mm/dd/yyyy):			
Complete count	Blood Count with platelet	Date of procedur	re (mm/dd/yyyy):			
Metabolic tests	panel with liver function	Date of procedur	e (mm/dd/yyyy):			
Alkaline pl	hosphatase	Date of procedur	e (mm/dd/yyyy):			
	Fluorescent in situ hy	bridization (FISH)				
	nt in situ hybridization Her2 Neu amplification		re (mm/dd/yyyy):			



HEALTH FAC	ILITY (HF)	
ADDRESS OF	HF	
APATIENT	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; o "same as above") 1. Last Name, First Name, Middle Name, Suffix	therwise, write,
	2. PhilHealth ID Number:	

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



Annex C.2: Checklist of Mandatory and Other Services for Surgery





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- PhilHealthOfficial X teamphilhealth

ase No.		
	CHECKLIST OF MANDATORY AND OTHER S	FRV

Breast Cancer - Post-Surgery HEALTH FACILITY (HF) ADDRESS OF HE 1. Last Name, First Name, Middle Name, Suffix A. PATIENT 🛘 Male 🗀 Female 2. PhilHealth ID Number (Answer only if the patient is a dependent; otherwise, write, B. MEMBER "same as above") 1 Last Name, First Name, Middle Name, Suffix 2. PhilHealth ID Number Place a (\checkmark) in the appropriate tick box. Clinical Staging, Laterality and Surgical Procedure a Left Right A. Clinical Staging: A. Clinical Staging: □ cStage o CStage o □ cStage IA CStage IA □ cStage IB CStage IB □ cStage IIA ☐ cStage IIA □ cStage IIB □ cStage IIB □ cStage IIIA □ cStage IIIA □ cStage IIIB □ cStage IIIB □ cStage IIIC □ cStage IIIC □ cStage IV □ cStage IV B. Procedure: (any of the following) B. Procedure: (any of the following) ☐ Partial mastectomy or lumpectomy ☐ Partial mastectomy or lumpectomy ☐ Subcutaneous/Simple/Total ☐ Subcutaneous/Simple/Total mastectomy mastectomy ☐ Modified Radical Mastectomy ☐ Modified Radical Mastectomy ☐ Partial mastectomy or Lumpectomy ☐ Partial mastectomy or Lumpectomy with sentinel lymph node biopsy with sentinel lymph node biopsy Partial mastectomy or Lumpectomy Partial mastectomy or Lumpectomy with axillary node dissection with axillary node dissection Total Mastectomy with sentinel ☐ Total Mastectomy with sentinel lymph node biopsy lymph node biopsy

^a If bilateral, tick in the appropriate box both laterality, its corresponding clinical staging and surgical procedure





☐ Modified Radical Mastectomy with

skin coverage for IIIB or above

☐ Modified Radical Mastectomy with

skin coverage for IIIB or above

Place a (\checkmark) in the appropriate tick box.

MANDATORY SERVICES	OTHER SERVICES
A. Diagnostics	
	☐ CBC with platelet count*
	☐ Chest X-ray PA and lateral views*
A CONTRACTOR OF THE CONTRACTOR	☐ Ultrasound of whole abdomen*
	□ ECG
	☐ Creatinine
	L PIPPIT
	□ GP Clearance
	FBS
	Electrolytes*
	□ Sodium
	□ Potassium / //
	□ Chloride
The Agency Country Cou	Calcium /
	Li Phosphate
	- 2 Ujinalysis* / 4
	2D echo**, 413
not required for estage o DCIS	
*not required for HER2 negative breast cancer	

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

DC: # Date: 3/2

Annex C.3: Checklist of Mandatory and Other Services for Chemotherapy





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(Case	No		11-11-11-11-11-11-11-11-11-11-11-11-11-		
		CHI			AND OTHER SE	RVICES
	HEA	LTH FAC	ILITY (HF)	ast Cancer - Che	momerapy.	
1	ADD	RESS OF	HF			
A. PATIENT 1. Last Name,			1. Last Name,	First Name, Midd	lle Name, Suffix	SEX □ Male □ Female
			2. PhilHealth			
	B. M	EMBER	"same as ab			otherwise, write,
	D.I		2. PhilHealth	A CALL STREET, SALES		
	Place		the appropriat NDATORY SI			R SERVICES ted/ as needed
	trea	tment prot	ljuvant	Date		
	A: AC+T	Zo21M1 Doxo Epiru Cyclo		(mm/dd/yyy) 1. 2.		
	Protocol A: AC+T	(C) Z021M1 : □ Doce	2 taxel (T)	1		
The second of the second	li.			1 2 34		
U. Marie	Protocol B: AC+Pacli	Z021N1	2 taxel (Pacli)	1		

	Protocol C: T+Cb	Zo21O1 □ Docetaxel (T) + Carboplatin (Cb)	1	
		☐ Adjuvant therapy	Date (mm/dd/yyy)	
	Protocol A: AC+T	Z021M21 □ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C) Z021M22	2. 3. 4. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
	Proto	□ Docetaxel (T)	3 4	
	H	Zo21N2; □ Doxorubicin/ Epirubicin (A) + Cyclophosphamide (C)	1.2	
	Protocol B: AC+Pacli	Z021N22	1. 3. 3. 3. 4. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5. 5.	
	Prote	□ Paclitaxel (Pacli)	7. 8. 9. 10. 11.	
70	Protocol C: T+Cb	Z021O2 ☐ Docetaxel (T) + Carboplatin (Cb)	1	
122/	100/	☐ Granulocyte colony- (G-CSF)	stimulating factor	
م م د د د	Date: 7			☐ Anti-emetic, specify☐ Antimicrobials, specify☐ Pain relievers, specify
	. 2C:	required for Stage o DCIS		☐ Other medicines, specify

TTD AT COTT TO A CY	TT TOTAL (TITE)	
HEALTH FAC	ILITY (HF)	
ADDRESS OF	HF	
A. PATIENT	1. Last Name, First Name, M	Iiddle Name, Suffix SEX □ Male □ Female
	2. PhilHealth ID Number	Telliale Telliale
B. MEMBER	(Answer only if the patic "same as above") 1. Last Name, First Name, M	ent is a dependent; otherwise, write, liddle Name, Suffix
	2. PhilHealth ID Number	
C** And C*********************************		
Certified corre	erby:	Conforme by,
Attendi	l name and signature) ng Medical Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No.		Date signed (mm/dd/yyyy)
Date signed (r	mm/uu/yyyy)	



Annex C.4.1: Checklist of Mandatory and Other Services for Hormonotherapy Tranche 1



Case No. _



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	. , C	HECKLIST OF MANDATO Breast Cancer – Hormo	ينمونونية غيث بقائون لاغراني	
	HEALTH FA	CILITY (HF)		
	ADDRESS C	FHF		
•	A. PATIENT	1. Last Name, First Name, 1	Middle Name, Suffix	SEX □ Male □ Female
	D. Marnanta	2. PhilHealth ID Number		THE SECOND STREET IN THE SECON
	B. MEMBER	(Answer only if the pati "same as above") 1. Last Name, First Name, I		therwise, write,
		2. PhilHealth ID Number		
	<u></u>		Place a (✓) in the a Clinical Staging a	ppropriate tick box.
	□ Righ		Sumear Staging ** **	
	CStage o		CStage o	
	CStage IA	00 200 070 1070 1070 1070 1070 1070 1070	eStage LA	
	CStage III	100000000000000000000000000000000000000	CStage IB CStage IIA	
	CStage II		cStage IIA	
	☐ cStage II		CStage IIIA	
	CStage II		CStage IIIB	
	cStage II	· · · · · ·	CStage IIIC	
Marie Control of the Control	cStage IV	ck in the appropriate box both latera	cStage IV	nical etaging
	-8 1	x in the appropriate box both fatera	ity and its corresponding ch	incar stagnig
۳> ۳	Date: 3/	Place a (v	() in the appropriate tic is done a	k box if the services nd indicate the date
MAST	SERVIC		DATE OF PRI (mm/de	
2	Tick one, wh	ichever is applicable	1. Date:	
	ä		3. Date:	
ng <u>ang ang antang ang a</u> ng ang ang ang	☐ Tamoxife		4. Date:	
	(Premen	opausal/Postmenopausal)		
	OR		6. Date:	





	1. Date:
	2. Date:
☐ Anastrozole / Letrozole b c (Aromatase Inhibitor)	3. Date:
(Postmenopausal)	4. Date:
	5. Date
	6. Date:

^aTamoxifen is given to premenopausal and postmenopausal women, particularly ER+/PR+/HER2neupatients. For postmenopausal ER+/PR+/HER2neupatients, an aromatase inhibitor is preferred b For cStage o – IIIC, prescription shall be given every 3 months c For cStage IV prescription shall be given every month.

Certified con		Conforme by: (Printed name and signature)
	ed name and signature) ttending Oncologist	(Printed name and signature) Patient
PhilHealth Accreditation No. Date signed		Date signed (mm/dd/yyyy)



Annex C.4.2: Checklist of Mandatory and Other Services for Hormonotherapy Tranche 2



Case No.



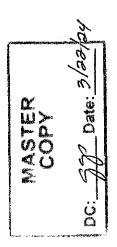
Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

$ \bot$ HEALTH FA	CILITY (HF)	onotherapy (Tranch	
ADDRESS C)F HF		
A. PATIENT	1. Last Name, First Name,	Middle Name, Suffix	SEX □ Male □ Fema
	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the pa "same as above") 1. Last Name, First Name,		otherwise, write
	³ 2. PhilHealth ID Number	- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
		Place a (🗸) in the a	appropriate tick box
\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \		l Clinical Staging a	
☐ Righ		口,Left	· ·
CStage o		☐ cStage 0	
CStage L	AND THE RESERVE OF THE PROPERTY OF THE PROPERT	cStage IA	
CStage II		cStage IB	
CStage II		cStage IIA	
CStage II		cStage IIB	
cStage II	and the second s	cStage IIIA	
cStage II	and the second of the second o	cStage IIIB	
CStage II		CStage IIIC	
cStage I		☐ cStage IV	·
If bilateral, t	ck in the appropriate box both later	ality and its corresponding o	linical staging
3/26	Place a	(\checkmark) in the appropriate ti	
ايق			and indicate the dat
SERVI	CES		ESCRIPTION ld/yyyy)
Tick one, w	nichever is applicable	7. Date:	
		8. Date:	
Tamoxif	on abc	9. Date:	
	opausal/Postmenopausal)		
OR	•	11. Date:	
OK			

7. Date:
8. Date:
9. Date:
10. Date:
11. Date:

^a Tamoxifen is given to premenopausal and postmenopausal women, particularly ER+/PR+/HER2neu-patients. For postmenopausal ER+/PR+/HER2neu+ patients, an aromatase inhibitor is preferred ^b For cStage o – IIIC, prescription shall be given every 3 months ^c For cStage IV prescription shall be given every month

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



Annex C.5.1: Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 1





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Case No CH	ECKLIST OF MANDATO Breast Cancer – Targeto	RY AND OTHER SERVICES
HEALTH FAC		a incrapy frames 5
ADDRESS OF	HF	
A. PATIENT	1. Last Name, First Name, N	Middle Name, Suffix SEX
	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 (✓) in the appropriate tick box. Clinical Staging *
□ Right		
cStage 0 cStage IA cStage IB cStage IIA cStage III cStage IIII cStage IIII cStage IIII cStage IIII cStage IIII	A Secretary of the secr	CStage IA CStage IA CStage IIA CStage IIA CStage IIIA CStage IIIB CStage IIIB CStage IIIC CStage IV
a If bilateral, tick		ity and its corresponding clinical staging () in the appropriate tick box if the services is done and indicate the date
	SERVICES	DATE OF PRESCRIPTION (mm/dd/yyyy)
•		1. Date:
□ Trastuzun	nah (H) ab	2. Date:
	uan (11)	3. Date:

4. Date:





	5. Date:
	6. Date:
□ 2D Echo ^c .	Date conducted:
	☐ Granulocyte colony-stimulating factor (G-CSF)
	☐ Antiemetic, specify:
	Antimicrobials, specify;
	📮 Pain relievers, specify:
	□ Other medicines, specify:

^a For Her2-positive breast cancer
^b One tranche is equivalent to 6 cycles; maximum of 3 tranches of targeted the apy once in a lifetime
^c Must be done every after 4th cycles of the targeted therapy

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



Annex C.5.2: Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 2





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Case No.	'	
CHECKLIST OF MANDATOR		
Breast Cancer - Targete	d Therapy (Tranche 2)	
HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT 1. Last Name, First Name, M	iddle 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 (✓) in the appropriate tick box.	
	linical Staging *	
Right	L let	
CStage 0	cStage o	
☐ cStage IA☐ cStage IB	CStage IA CStage IB	
CStage IIA	stage IIA	
CStage IIB	cStage IIB	
CStage IIIA	CStage IIIA	
CStage IIIB	CStage IIIB	
Stage IIIC	CStage IIIC	
CStage IV	CStage IV	
^a If bilateral, tick in the appropriate box both laterali		
Place a (✓) in the appropriate tick box if the services is done and indicate the date		
CEDITION	DATE OF PRESCRIPTION	
SERVICES	(mm/dd/yyyy)	
	7. Date:	
	8. Date:	
	9. Date:	
☐ Trastuzumab (H) ^{a b}	10. Date:	
	11 Date:	

12. Date:

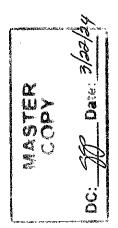




SERVICES	DATE OF PRESCRIPTION (mm/dd/yyyy)
□ 2D Echo °	Date conducted:
The Conference of the Parket Conference of the C	☐ Granulocyte colony-stimulating factor (G-CSP)
	Antiemetic, specify:
	☐ Antimicrobials, specify:
	Pain relievers, specify:
	Other medicines, specify.
^a For Hera-positive breast cancer	

^a For Her2-positive breast cancer
^b One tranche is equivalent to 6 cycles; maximum of 3 tranches of targeted therapy once in a lifetime
^c Must be done every after 4th cycles of the targeted therapy

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



Annex C.5.3: Checklist of Mandatory and Other Services for Targeted Therapy - Tranche 3



Case No. _



Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

CHECKLIST OF	MAND	ATORY AN	D OTHER S	ERVICES
T	tori	. Tant		The state of the s

	Breast Cancer - Targete	d Therapy (Tranche	2)
HEALTH FAC	ILITY (HF)		
ADDRESS OF	HF		
A. PATIENT	1. Last Name, First Name, M	iddle Name, Suffix	SEX □ Male □ Female
	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the patie "same as above") 1. Last Name, First Name, M		therwise, write,
n de la composition de la composition La composition de la	2. PhilHealth ID Number		
		Place a (🗸) in the ap	propriate tick box.
	Laterality and C	linical Staging a	
□ Right		Left,	
☐ cStage o		CStage 0	
CStage IA	eralis della servicia	CStage IA	
CStage IB		L eStage IB	
CStage IIA		CStage IIA	
CStage IIB	The state of the s	cStage IIB	
CStage IIIA	* - * * * * * * * * * * * * * * * * * *	☐ cStage IIIA	,
CStage IIIB		☐ cStage IIIB	
CStage IIIC		☐ cStage IIIC	
☐ cStage IV	· · · · · · · · · · · · · · · · · · ·	☐ cStage IV	

a If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

Place a (\checkmark) in the appropriate tick box if the services is done and indicate the date

AND COP	: 9 Date: 3/22/24
	20

SERVICES	DATE OF PRESCRIPTION (mm/dd/yyyy)
□ Trastuzumab (H) ^{a b}	13. Date:
	14. Date:
	15. Date:
	16. Date:
	17. Date:
	18. Date:



SERVICES	DATE OF PRESCRIPTION (mm/dd/yyyy)
□ 2D Echo °	Date conducted:
	Granuleeyte colony-stimulating factor (G-CSF)
	☐ Antiemetic, specify:
	Antimicrobials, specify:
	Other medicines, specify:
Vor Horo positive Wast Janear	

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



^a For Her2-positive breast cancer
^b One tranche is equivalent to 6 cycles; maximum of 3 tranches of targeted therapy once in a lifetime
^c Must be done every after 4th cycles of the targeted therapy

Annex C.6: Checklist of Mandatory and Other Services for Surveillance





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Case	Ma			
Cast	TAG.			

CHECKLIST OF MANDATORY AND OTHER SERVICES Breast Cancer - Surveillance

Breast Cancer – Surveillance			
HEALTH FACILITY (HF)		in a second district in particular	
ADDRESS OF	HF		
A. PATIENT	1. Last Name, First Name, N	liddle Name, Suffix SEX ☐ Male ☐ Female	
	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the pation	nt is a dependent; otherwise, write,	
	"same as above")		
	1. Last Name, First Name, M	liddle Name, Suffix	
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pada pada kanada Kanada kaya mada	2. PhilHealth 1D Number		
<u>É</u>		Place a (✓) in the appropriate tick box.	
	Laterality and (linical Staging *	
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CStage IA		CStage IA	
☐ cStage IB	and the state of t	CStage IB	
CStage IIA	As a distribution of processing of the Cartal States	Stage ILA	
☐ cStage IIB		cStage IIB	
☐ cStage IIIA		Stage IIIA	
CStage IIIF		☐ cStage IIIB	
CStage IIIC		☐ cStage IIIC	
☐ cStage IV		☐ cStage IV	
	in the appropriate box both lateral	ity and its corresponding clinical staging	

	Place a () in the appropriate tick box	
Basic Services		
☐ Mammography (contralateral if mastectomy or bilateral, if lumpectomy) c AND/OR	Date conducted (mm/dd/yyy):	
☐ Ultrasound breast e or whole d abdomen AND/OR	Date conducted (mm/dd/yyy):	
☐ Gynecological evaluation and Transvaginal ultrasound f AND/OR	Date conducted (mm/dd/yyy):	
☐ Chest X-Ray b AND/OR	Date conducted (mm/dd/yyy):	
□ Clinical Consultation ^a	Date of Consultation (mm/dd/yyyy):	
A STATE OF THE STA		



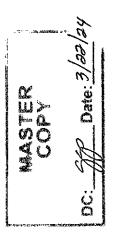


Specific Services		
□ 2D echo g AND/OR	Date conducted (mm/dd/yyy):	
☐ Bone densitometry h AND/OR	Date conducted (mm/dd/yyy):	
☐ Bone scan ⁱ	Date conducted (mm/dd/yyy):	

Rules on surveillance

- a Clinical consultation after completion of treatment, every 3-4 months for 1st 3 years particularly for high risk patients (Stage IIB-IIIC) then once every year if asymptomatic; every month if Stage IV.
- b Chest X-ray once a year, as needed
- c Can be availed of post-surgery, as needed, maximum of one (1) availment per year
- d Ultrasound of whole abdomen, once a year, if needed
- e Ultrasound of breast, once a year, if needed
- f Gynecological exam and transvaginal ultrasound, once a year if on hormonotherapy.
- g 2D echo, as per cardiology advice, once a year, after completion of treatment cycle of doxorubicin or
- h Bone densitometry, once a year if on aromatase inhibitor
- i Bone scan, as needed, once a year if symptomatic:

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



PhilHealth



Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health 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	□ Orthopedic implants
	□ Breast cancer	☐ PD First Z benefits
	□ Prostate cancer	□ Colorectal cancer
	☐ Kidney transplantation	□ Prevention of preterm delivery
	□ Cervical cancer	☐ Preterm and small baby
	□ Coronary artery bypass surgery	☐ Children with developmental disability
	☐ Surgery for Tetralogy of Fallot	☐ Children with mobility impairment
	□ Surgery for ventricular septal defect	☐ Children with visual disability
	□ ZMORPH/Expanded ZMORPH	☐ 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.			
T E	Date: 3/02/04	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		
1 2 C C C C C C C C C C C C C C C C C C	if it	Page 1 of 2 of Annex l		

Annex D: Z Satisfaction Questionnaire

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: cup excellent cup satisfactory cup unsatisfactory cup don't know
9.	If you have other comments, please share them below:
200	Thank you. Your feedback is important to us!
	Signature of Patient/ Parent/ Guardian Date accomplished:

Annex E.1: Checklist of Requirements for Reimbursement – Diagnostic Test and Prognostication



Case No.



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	HEALTH FACILITY (HF)			
ADDRESS OF HF				
	A. PATIENT	1. Last Name, First Name, M		EX Male □ Female
		2. PhilHealth ID Number		
	B MEMBER	(Answer only if the patie "same as above") 1. Last Name, First Name, M		erwise, write,
		2. PhilHealth ID Number		
	В	CKLIST OF REQUIREMENT reast Cancer - Diagnostic the appropriate tick box.		
		Requirements		Please Check
	(Annex E.1			
	2. Photocopy of completely accomplished Eligibility Criteria for Diagnostic Test (Annex A.1)			
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) 4. Properly accomplished PhilHealth Claim Form (CF) 2 5. Checklist of Mandatory and Other Services (Annex C.1-Diagnostic Test Breast CA)				
	6. Completed	Z Satisfaction Questionnaire		
	(SOA) or it	r certified true copy (CTC) of t	ne Statement of Account	
and the same of th	8. Transmittal Form (Annex H) DATE COMPLETED (mm/dd/yyyy):			
DATE FILED (mm/dd/yyyy):				
<u>~</u>	Certifie	ed Correct by:	Conforme by:	
	(Printed name and signature) Attending Physician		(Printed name a Patie	nt
	PhilHealth Accreditation		Date signed (mm/dd/)	уууу)
V. Z	Date signed (۱	mm/dd/yyyy)	1	
			· .	



Annex E.2: Checklist of Requirements for Reimbursement – Surgery



Case No.



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HEALTH FACILITY (HF)				
ADDRESS OF HF				
All the state of t				
A. PATIENT 1. Last Name, First Name, M				
	□ Male □ Female			
2. PhilHealth ID Number				
	ent is a dependent; otherwise, write,			
"same as above")				
1. Last Name, First Name, A	fiddle Name, Suffix			
2. PhilHealth ID Number				
CHECKLIST OF REQUIREME	NTS FOR REIMBURSOMENT			
Breast Cancer - Si				
Place a 🗸) in the appropriate tick box.				
Requirements	Jan Please			
	the Check			
1. Checklist of Requirements for Reimburse				
2. Properly accomplished PhilHealth Clain	Form (CP) 1 or PhilHealth			
Benefit Eligibility Form (PBEF)				
3. Properly accomplished PhilHealth Claim	Form (C)			
4. Photocopy of approved Pre-authorization Checklist and Request				
(Annex A.2)				
5. Photocopy of Member Empowerment Form (Annex B)				
6. Checklist of Mandatory and Other Services (Annex C.2) 7. Completed Z Satisfaction Questionnaire (Annex D)				
8. Transmittal Form (Annex H)				
9. Photocopy of multidisciplinary – interdis	ciplinary team (MDT) plan			
10. Original or certified true copy (CTC) of the Statement of Account				
(SOA) or its equivalent				
11. Photocopy of accomplished surgical oper				
12. Photocopy of accomplished anesthesia re	port			
13. Photocopy of histopathology report				
DATE COMPLETED (mm/dd/yyyy):				
DATE FILED (mm/dd/yyyy):				
Certified correct by:	Conforme by:			
(D) 1				
(Printed name and signature)	(Printed name and signature)			
Attending Surgeon PhilHealth	Patient Date signed (mm/dd/yyyy)			
Accreditation	Date signed (min/dd/yyyy)			
Date signed (mm/dd/yyyy)	1			
388				





Annex E.3: Checklist of Requirements for Reimbursement – Chemotherapy



Case No.



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		The state of the s	
ADDRESS OF	HF		in the state of th
A.PATIENT	1. Last Name, First Name,	1 100000 100000 100000 100000 100000 100000 100000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 100000 10000 10000 10000 10000 100000 100000 10000 10000 10000 100000 10000 10000 10000 10000 10000 10000 100000 10000 10000 1000	X Male □ Fem
	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the pat "same as above") 1. Last Name, First Name,	i ent is a dependent; oth Middle Name, Suffix	erwise, write
	2. PhilHealth ID Number		
4.	CKLIST OF REQUIREMI Breast Cancer - the appropriate tick box.	ENTS FOR REIMBURSE - Chemotherapy	
	Requirement		Please Check
(Annex E.3		THE PARTY OF THE P	
2. Photocopy (Annex A.2	of approved Pre-authorizatio)	on Checklist and Request	
PhilHealth	complished PhilHealth Clair Benefit Eligibility Form (PB	EF)	
	complished PhilHealth Clair		
	of Member Empowerment F f Mandatory and Other Serv		
	Z Satisfaction Questionnaire		
	cer Treatment Passport (Ani		
	l Form (Annex H)		
	of the multidisciplinary – in	terdisciplinary team (MDT)	
plan			
	certified true copy (CTC) of	the Statement of Account	
	s equivalent		
	ETED (mm/dd/yyyy):	· · · · · · · · · · · · · · · · · · ·	
	(mm/dd/yyyy):		
Certified correct by:		Conforme by:	
i ing			
(Printed Atte	name and signature)	(Printed name and	signature)
Attending Oncologist		Patient	
PhilHealth Accreditation No. Date signed (r	nm/dd/yyyy)	Date signed (mm/dd/yyyy)



Annex E.4.1: Checklist of Requirements for Reimbursement – Hormonotherapy Tranche 1





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Case No					
HEALTH FAC	ILITY (HF)				
ADDRESS OF HF					
A. PATIENT	1. Last Name, First Name,	Middle Name, Suffix SEX Male Female			
	2. PhilHealth ID Number				
B. MEMBER		ent 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					
Breast Cancer – Hormonotherapy Tranche 1					
		Place a (\checkmark) in the appropriate tick box.			
	Requirements	Please Check			
	Requirements for Reimburs				
	Hormonotherapy Tranche 1 (Annex E.4.1)				
	Request (Annex A.2) 3. Properly accomplished PhilHealth Claim Form (CF) 1 or				
3. Properly accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)					
	Mandatory and Other Servi				
9. Transmittal Form (Annex H)					
10. Photocopy of the multidisciplinary – interdisciplinary team					
(MDT) plan					
11. Original or certified true copy (CTC) of the Statement of					
Account (SOA) or its equivalent					
DATE COMPLETED (mm/dd/yyyy):					
DATE FILED (mm/dd/yyyy):					
Certified Correct by:		Conforme by:			
(Printed name and signature)		(Printed name and signature)			
Attending Oncologist		Patient			
PhilHealth Accreditation No. Date signed (mm/dd/yyyy)					
Date signed (m	m/aa/yyyy)				

Annex E.4.2: Checklist of Requirements for Reimbursement - Hormonotherapy Tranche 2



Case No.



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ADDRESS OF I	LITY (HF)	7 (2000) (1947) (1947)	Merican de la companya della companya della companya de la companya de la companya della company	
ADDRESS OF I	if			
A. PATIENT	1. Last Name, First Name,	Middle Name, Suffix		X Male Female
	2. PhilHealth ID Number			
B. MEMBER	(Answer only if the pat "same as above") 1. Last Name, First Name,			erwise, write,
	2. PhilHealth ID Number			
СНІ	ECKLIST OF REQUIREM Breast Cancer – Horn	onotherapy Trai	iche 2	
	Requirements			Please Checl
1. Checklist c	f Requirements for Reimbur	sement#		:
	herapy Tranche 2. (Annex E.,			
2. Photocopy	of approved Pre-authorization	on Checklist and Rec	γuest	
(Annex A.:				
	ecomplished PhilHealth Clair			
	Benefit Eligibility Form (PB			
	ccomplished Philtealth Clair			
	of Member Empowerment F			
	of Mandatory and Other Serv			
	l Z Satisfaction Questionnaire acer Treatment Passport (Ann			
	al Form (Annex H)	iex r)		
	of the multidisciplinary – in	terdisciplinam team		
(MDT) pla	_ ·	ceraiscipiniary ceam	•	
	c certified true copy (CTC) of	the Statement of Ac	count	
	ts equivalent			
DATE COMPL	ETED (mm/dd/yyyy):			
DATE FILED	(mm/dd/yyyy):			
Certified corre	ct by:	Conforme by:		
(Printe	d name and signature)	(Printed n	ame an	d signature)
Att	ending Oncologist		Patien	rt
PhilHealth Accreditation No.	nm/dd/yyyy)	Date signed (mm	/dd/yy	уу)
TERMITE SIGNED FO				



Annex E.5.1: Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 1





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	Case No						
	HEALTH FA	CILITY (HF)					
	ADDRESS OF	F HF					
	A. PATIENT	1. Last Name, First Name, Mic		EX Female			
		2. PhilHealth ID Number					
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		2. PhilHealth ID Number					
		HECKLIST OF REQUIREME Breast Cancer – Targeto		propriate tick box.			
	<u>ن</u> ا	Requirements		Please Check			
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	(Annex E.						
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		accomplished PhilHealth Claim h Benefit Eligibility Form (PBE)					
		accomplished Philitealth Claim					
		y of Member Empowerment For					
		of Mandatory and Other Service					
		d Z Satisfaction Questionnaire (
		ncer Treatment Passport (Anne	<u>x F)</u>				
		tal Form (Annex H)	ndigainlinam taon (MDT)	<u> </u>			
	plan	y of the multidisciplinary – inte	roiscipiniary team (MD1)	'			
		or certified true copy (CTC) of th	e Statement of Account				
		its equivalent					
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	PhilHealth	ttending Oncologist	Patie: Date signed (mm/dd/yy				
	Accreditation No.						
	Date signed (mm/dd/yyyy)					



Annex E.5.2: Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 2





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Case No			
HEALTH FACII	JTY (HF)		
ADDRESS OF H	IF		Na.
	T 127 T 127		
A. PATIENT 1	ı. Last Name, First Name,	5T	SEX □ Male □ Female
	2. PhilHealth ID Number		NAMES OF THE PARTY
		ient is a dependent; ot	herwise, write,
	"same as above")		a de la companya de l
	1. Last Name, First Name,	Middle Name, Suffix	
	2. PhilHealth ID Number		4.4 James consum Mayor
	(1) and (1) an	ENTS FOR REIMBURSI	*****
	reast Cancer – Target	ed Therapy (Tranche 2	, · · · gallia
Ampro 13 de 15 Sulta de la companya de 15 Partir de 15 de 15 de 15 Partir de 15 de 15 de 15 de 15 Partir de 15 de 15 de 15 Partir de 15		Place a (✓) in the appr	Please
49513331 49513321 10513221 10513221	Requirements		Check
	equirements for Reimburs	sement – Targeted Therapy	¥
(Annex E.5.2)			
2. Photocopy of a (Annex A.2)	approved Pre-authorizatio	n Checklist and Request	
	mplished PhilHealth Clain	n Form (CF) 1 or	
PhilHealth Be	nefit Eligibility Form (PBI	3F).	
	mplished PhilHealth Clain		
	Member Empowerment Fo		
	Iandatory and Other Servi		
	Satisfaction Questionnaire		
	Treatment Passport (Ann	ex F)	
9. Transmittal Fo		andinainline material (MDT	<u></u>
plan	the multidisciplinary – int	erdisciplinary team (MDT)
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DATE FILED (m			
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	nme and signature)	(Printed name and	signature)
	ing Oncologist	Patient	
PhilHealth Accreditation No.		Date signed (mm/dd/yyy	y)
Date signed (mm	/dd/yyyy)		

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Annex E.5.3: Checklist of Requirements for Reimbursement – Targeted Therapy Tranche 3





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 X teamphilhealth

Case No		1	
HEALTH FAC	ILITY (HF)		
ADDRESS OF	HF	And the second s	
A. PATIENT	1. Last Name, First Name, M	iddle Name, Suffix SEX	\Box Female
en und som komen in den det den Postore imperior inden stad mark de plum armen en or	2. PhilHealth ID Number		
B. MEMBER	(Answer only if the patie "same as above") 1. Last Name, First Name, M	iddle Name, Suffix	e, write,
	2. PhilHealth ID Number		
СНЕ	CKLIST OF REQUIREMEN Breast Cancer – Targete	NTS FOR REIMBURSEMENT d Therapy (Tranche 3) Place a (√) in the appropriate	
	Requirement		Please Check
1. Checklist of (Annex E.5.	Requirements for Reimburse 3)	nent Targeted Therapy	
2. Photocopy o A.2)	f approved Pre-authorization	Checklist and Request (Annex	
	omplished PhilHealth Claim ; bility Form (PBEF)	Form (CF) 1 or PhilHealth	
	complished PhilHealth Claim		
	f Member Empowerment For	· · ·	
	Mandatory and Other Service		
	Z Satisfaction Questionnaire (
	er Treatment Passport (Annex	x F)	
	Form (Annex H)	1: 1: 1: (1.65.00) 1	
		rdisciplinary team (MDT) plan	
or its equiva		e Statement of Account (SOA)	
	ETED (mm/dd/yyyy):		
DATE COMPLETED (
Certified correc	et by:	Conforme by:	
	name and signature)	(Printed name and signat	ture)
	ending Oncologist	Patient	
PhilHealth Accreditation No. Date signed (m	um/dd/yyyy)	Date signed (mm/dd/yyyy)	





Annex E.6: Checklist of Requirements for Reimbursement - Surveillance





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Case No.			
HEALTH FACILITY (HF)			
ADDRESS OF HF		The state of the s	
A. PATIENT 1. Last Name, Fin	rst Name, Mide	dle Name, Suffix SE	X Male
2. PhilHealth II			
"same as aboy	e")	is a dependent; othe de Name, Suffix	rwise, write,
2. PhilHealth II) Number		
	OUREMENT st Cancer - S	S FOR REIMBURSEN urveillance	VENT
Place a $(\sqrt{\ })$ in the appropriate ti			
Requ	uirements		Please Check
1. Checklist of Requirements f	or Reimburser	nen t – S urveillance	
2. (Annex E.6)	sorth out at the		
3. Photocopy of approved Pre- (Annex A.2)		Checkust and Request	
4. Photocopy of Member Emp	owerment For	m (Annex B)	
5. Properly accomplished Phil	Health Claim I	form (CF) 1 or	
PhilHealth Benefit Eligibili			
6. Properly accomplished Phil	(01.0		
7. Checklist of Mandatory and8. Completed Z Satisfaction Q			
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(SOA) or its equivalent	p, (010) 01 th	Deatomont of Hoovant	
10. Transmittal Form (Annex F	I)		
DATE COMPLETED (mm/dd/y	уууу):		
DATE FILED (mm/dd/yyyy):	·		
Certified correct by:		Conforme by:	
(Printed name and signs	ature)	(Printed name an	d signature)
Attending Physician	n	Patien	
PhilHealth Accreditation No.		Date signed (mm/dd/y	ууу)
Date signed (mm/dd/yyyy)			

Annex F: Breast Cancer Treatment Passport





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Case No		
HEALTH FAC	LITY (HF)	
ADDRESS OF	HF	AGE:
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX Male Female
	2. PhilHealth ID Number	0000-0
B. MEMBER	(Answer only if the patient is a dependent "same as above") 1. Last Name, First Name, Middle Name, Suffix	; otherwise, write,
	2. PhilHealth ID Number	0000-0

Breast Cancer Treatment Passport

Cytotoxic Chemotherapy

Name of Drug		Dosage Preparation	Date Initiated	Patient/ Parent/	Attending Physician's	
Generic Name	Brand Name		_	(mm/dd/yyyy)	Guardian's Signature	signature
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.				· · · · · · · · · · · · · · · · · · ·		
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15.						
16.		3/22/				







Page 1 of 2 of Annex F

B. Hormonotherapy

Name of Drug			_	Date	Patient/ Parent/	Attending
Generic Name	Brand Name	Dosage	Preparation	Given (mm/dd/yyyy)	Guardian's Signature	Physician's signature
1.						
2.						
3.						
4.						
5.			-			
6.						
7.						
8.						
9.						
10.						
11.						
12.						

C. Targeted Therapy

Name of Drug				Date	Patient/ Parent/	Attending
Generic Name	Brand Name	Dosage	Preparation	Given (mm/dd/yyyy)	Guardian's Signature	Physician's signature
1.						
2.						
3⋅						
4.				-		
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11.						
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15.	7					
16.	7					
17.	10,11					
18.						

Annex G: Checklist for Patient Transfer



Case No.



Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

- Citystate Centre, 709 Shaw Boulevard, Pasig City
- (02) 8662-2588 ⊕www.philhealth.gov.ph
 PhilHealthOfficial X teamphilhealth

HEALTH FACILITY (HF)							
ADDRESS OF H	ADDRESS OF HF						
A PATIENT 1.	Last Name, F	irst Name,	Middle Name,	Suffix SEX □ Male □ Female			
2	. PhilHealth I	D 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 FOR PATIENT TRANSFER Z Benefits Package for Breast Cancer For breast cancer patients enrolled in the Z benefits who will be transferred to a referral contracted HF, the following checklist shall be accomplished:							
NAME OF REFE				Hedi			
ADDRESS OF R	EFERRAL CO	NTRACTE) Arc	Special State of the Control of the			
Requirer	nents.	YES (tick a	OR NO ppropriate box)	Signature of Responsible Person			
1. Updated M Abstract		☐ Yes	, No □ No				
2. Letter of R the Attending Phy	eferral from sician	☐ Yes	□ No	Name and Signature Attending Physician			
the breast cancer	rue copy of treatment	☐ Yes	□ No	·			
passport				Name and Signature Z Benefits Coordinator			
4. Letter of In the patient reques transfer to a refer		☐ Yes	□ No	Name and Signature Patient/Parent/Guardian			
HF (Annex I)							
HF (Annex I) Certified complete	e by:		Conforme				
Certified complete	name and sign						





Annex H: Transmittal Form of Claims for the Z Benefits





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

- Citystate Centre, 709 Shaw Boulevard, Pasig City
- € (02) 8662-2588 ⊕www.philhealth.gov.ph
- Phill-lealthOfficial X teamphilhealth

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 Benefits Package Code, include the code for the order of tranche payment, treatment phase, sessions or cycles, as applicable. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

Case Number	Name of Patient	Period of Confinement			Remarks
	(Last, First, Middle Initial, Extension)	Date admitted	Date discharge	d Package Code	
	Extension)				
1.					
2.		ــــــــــــــــــــــــــــــــــــــ			
3.					
4.		Paragraph & Carrier of			
5.					
6.					
7.					

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

Page 1 of 1 of Annex H

	lee/e
	Date
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Annex I: Letter of Intent for Transfer to a Contracted Health Facility





Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

Page 1 of 2 of Annex I

- Citystate Centre, 709 Shaw Boulevard, Pasig City
 (02) 8662-2588 ⊕ www.philhealth.gov.ph
 PhilHealthOfficial X teamphilhealth

Case No		
HEALTH FAC	ILITY (HF)	
ADDRESS OF	HF	
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	2. PhilHealth ID Number	000-0
B. MEMBER	(Answer only if the patient is a dependent; "same as above") 1. Last Name, First Name, Middle Name, Suffix	otherwise, write,
	2. PhilHealth ID Number	
Letter	of Intent for the Transfer of Care to a Referr	al Contracted HF
	(Name of the Patient)	born on, (Date of Birth)
agey was diagnosed	ears old, residing at(Address))n
at the	(Diagnosis) (Name of the Referring Contracted HF)	(Date: mm/dd/yyyy)
We would like	request for transfer of Breast Cancer Care to(Na	me of Referral Contracted HF)
under the care	of (Name of the Attending Physician)	
	d that upon transfer to a referral contracted HF, ims as the referring contracted HF.	we will have to waive all

	HEALTH FACIL	ITY (HF)	·	
	ADDRESS OF H	F		
	A PATIENT 1	. Last Name, First Name	, Middle Name, Suffix	SEX □ Male □ Female
	2	. PhilHealth ID Number	: 00-00000	100-0
	il a proposition of	Answer only if the pa same as above") . Last Name, First Name	tient is a dependent; o	otherwise, write,
		. PhilHealth ID Number		The second secon
	Conforme by:		Certified correct by:	
		me and signature). Parent/Guardian	Attending Physician, R	e and signature) Referring Contracted HF
	Date signed (mr	n/dd/yyyy)	PhilHealth Accreditation No. Date signed (mm/dd/yy	VA)
¦w are armonosekoses !	managh sam i		Pace Signed (mm/ dd/ yy	
MASTER COPY	Date: 3/22/			and signature) Referring Contracted
\$0	DC:			ÎF
I он жаатыны окуунулганда жааты	Acknowledged b	ya.	Acknowledged by:	
		me and signature)	Head or Z Benefits (and signature) Coordinator, Referral cted HF
	PhilHealth Region	thorized Signatory, onal Office Referring Contracted	Contra	cted fir
	HF five working da scanned	to the referring Contracted ys upon receipt of the form; copy is allowed)		
	Date signed (mr	n/dd/yyyy)	Date signed (mm/dd/yy	yy)

Annex J.1: Sample CF2 for Diagnostic Test or Prognostication

SAMPLE CLAIN	1 FORM 2 FOR DIA	AGNOSTIC TEST C	R PROGNOST	ICATION CONTRACTOR	Managaratus
PhilHealth Force Partner in Health	Citystai Call Conte	Republic of the Philippines ALTH INSURANCE CO e Centre 709 Share Boulevard, Pasty (102) 441-7442 * Trunkline (02) 4 www.philhoulth.gov.ph nilk ection.center@philhealth.gov.ph	Cay 41-7444	CF-2 (Claim Form 2) Revised September 2918	
This form together with other suppo All Information, fields and trick bow FALSE/INCORRECTINFORMATION	Number (PAN) of Health C	a sixty (BI)) calendardays from date: Jaim forms with incomplete informa IE SUBJECT TO CRIMINAL, CIVIL O CARE INSTITUTION (HCI) Ire Institution: he is 1,9 13	cion shall not be processed. RADMINISTRATIVE LIABILI	TIES.	Indicate the date of the procedure was done
2. Name of Health Care Ins	ABCDF Medic SHAW BLVD	al Center PASIG CIT	Letti delet vili delet vili delet esperimente en esperimente esperimente de la presenta del presenta de la presenta del presenta de la presenta del presenta de la presenta del presenta de la presenta del presenta de	መስፈተር ነው	Write OUTPATIENT
3.Address:	iliding Number and Street Marie	energymanny districted. Applying gregory reprovements to solid Allibrare.	nicipality	-manana na paramana panana tata <mark>manana manana mana. m</mark> Province	in lieu of time admitted &
	PART II - PAT	IENT CONFINEMENT INF	ORMATION		discharged
1.Name of Patient:	DELA CRUZ	JUANA	- bandamahada panggang panggang panggang	MAPAGPALA	
	Last Name	First Marne	Namo Extension (#758.41)	Middle Name (or: DELACRUZ IUNH JR SIPAR)	
A NO L AEZ	ne of referria g Health Care Institution	Building Number and Street 1	TO THE COMMENTATION OF THE CONTRACT OF THE CON	Province Province Province Province	Nahara C
	a. Date Admitted 0.3 -3.0 c. Date Discharge 0.3 -3.0 day	r-12 17 4 d. TimeDisc	harpourpatient	AN LIPH	Tick YES if the patient
4.Patient Disposition: (sete	(tonly1) e. Expired			AN TIPM	was referred by another HF
b. Recovered	Samuel Manager	Industrialy Telegraphics Medianed		Nis book book	by another fir
🗍 c. Home/Discharged Ag	and the state of t	хе хамана Айтан не понятни остатого, отнежность не жизот стана да да прада то	Minimo de Proprimi Pédath Cricini	Decres Parkary. Characteristics are a compared by the compared	2607A
d. Abeconded	- Reason/s	Building Number and Street No for referrol/PointSer:	era Ciy/Muekipalty	Римскос Ларкий	is
5. Type of Accomodation: 6. Admission Diagnosis/es 7. Discharge Diagnosis/es Breast Cancer	Breast Cancer Use additional CF2 if necessary): This Code/h Related Procedu	re/s (f thore's any) Res Co.	Eighe of Federicates Administration of the Control	Leterality (check applicable box	setting
b. Special Consideration:	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	An international and the second of the secon		left right bot	Tick the box for the laterality
a. For the following repetitive by Hernodialysis Peritoneal Dialysis	o neck box that capitas and	Stand Tri	A STATE OF THE STA	iothuracy, sne guid sines.	Indicate the diagnosis
Radiotherapy (MAC) Radiotherapy (COSAL) b. For Z-Benefit Peckage c. For MCP Package tenumerate	four dates (mm-dd-year) of pro-nasal	ZO21A1	abitienta		Indicate the appropriate "benefit package code"
f. For Newborn Core Package For Essential Newborn Car Internation daying of newb Endyskin-to-skin contact g. For Outpatient HIVEADS Trea	e the dates (mm-cld-year) when the for bay 3 ARV Essential Newborn Care e (check applicable boxes) Thouly cost charping Bye Prophytics		RIG Newborn Screening Te		Management of the second of th
9. PhilHealth Benefits:					<u> </u>
ICD 10 or RVS Code: #####	E.P. Steen Dookes	A Allahadan paga ang ang ang ang ang ang ang ang ang	Second Case Rate	ger er engelen en en et en extente en	AN AND AN AND AND AND AND AND AND AND AN

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Accreditation Fig. 1234-5557890172 (sgd) MARY DELA ROSAS, MD Signature Over Printed Name					No co-pay ontop of	Phic. bi burne between the server of he		if patient paid
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	Date Signed: L	class 1 - 1 - 1 day 1 - 1 - 1 yet	ann Annan d	Broattand	1	resident and former and references to resident and references to an extending and resident		Professional fee
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		ann day yo			With our pay on top i	of Philitealth Benefit. P	"- F	Tick this box
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	Total Health Care Instit	ution Fees		 -		tal Actual Charges*		No co- payment
	Total Professional Fee:	······						Payment
	Gracel Total				3,5	00.00		
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			n Statement of Account (SQA)	***************************************		anggag fi Ti Masakin da kabang panggan ng panggan kabil da manamanin manggan ng mga paggan fili da da mahanin		
ONS	ENT TO ACCESS F	ATIENT RECORD/S:						Affix signatu
heret.	y consent to the submis	ssion and examination of	the patient's pertinent medical re	cords for	the purpose of veri	fying the veracity of this claim to effect	and the same	of the
	it processing of benefit v hold PhilHealth or an		and/or representatives free from	anyana	f oli legal liabilities i	elative to the herein-mentioned consent	7	patient/pare
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l cer	CARDING DE	OS REYES	patient's chart and health care i RECORD)とした。	in recoras ana inai: -ICER	the barein information given are true and correlated to the Date Signed: 0 4 0 1 2 0 2	~~ I	representati

SAMPLE CLAIM	FORM 2 FOR BR	EAST CANCER (S	URGERY)	This form may be reproduced and	
PhilHealth	Chysta Call Cente	Republic of the Philippines ALTH INSURANCE C te Centre 709 Shaw Boulevard. Peolg r (02) 441-7442 * Trunkline (02) 4 www.philhealth.gov.ph asil: actioncenter@philhealth.gov.ph	Chy 11.9444	(Claim Form 2) Revised September 2018	
IMPORTANT REMINDERS: PLEASE WRITE IN CAPITAL LETTERS AN This form together with other supportion All information, fields and trick boxes re FALSEAMOORRECT INFORMATION OF 1. Phillhealth Accreditation N 2. Name of Health Care Instit 3. Address:	g decements should be filed with quiest in this form are necessary; MISREPRESENTATION SHALL PARTIL HEALTH umber (PAN) of Health C	in slay (53) calendar days from date Chaim forms with incomplete inform BE SUBJECT TO CHIMINAL, CIVIL (GAREINSTITUTION (HC) are institution: H.9.3	SEION SHALL NOT BE PROCESSED. SHADMINISTRATIVE LIABILY INFORMATION 1010 X X X X X	TIES.	Indicate the date of admission and discharge Indicate the time of admission and
Build	ing Number and Street Name		nicipality	Province	time of discharge
1. Name of Patient: 2. Was patient referred by an	DELA CRUZ Last Name	TIENT CONFINEMENT INF JUANA First teams	ORMATION Note Extension (SYSTATE	MAGTIBAY Midd # Name (modLACR / JANKJESFAG)	discharge
3. Confinement Period: **	e. Expired E. Transfero st Medical Advise Reason,6]- <u>[2 </u>	there 12:20 miles Time: Lary: Large Name of Beterralises the Carelin	PROLITICS ZIP CINTS AM PM PN AM PM PN AM PM CONTROL OF THE CON	Tick YES if the patient was referred by another
6.Admission Diagnosis/es: 7.Discharge Diagnosis/es (Ustanosis CD-Breast Cancer_BReast Cancer_BR	Breast Cancer	chapping somewasses prices corrector meritor for hyposomics were measurements	Date of Philosophure Date of Philosophure	test right bosh test test test test took	Tick the box for the laterality
8. Special Considerations:	Andrew Commission of the Commi		AND	. left right both	phydicia
a. For the following repetitive proce Hemodialysis Peritonani Dialysis Radiotherspy (LINAC)	chares, chack box that applies	Beautyte	HERDY SAME SAME SAME SAME SAME SAME SAME SAME	COLLEGE OF SECTION OF SECTION	Indicate the diagnosis
Radiothirapy COSAUT b. For 2-Senefit Package c. For MCP Package featurerate for 1 d. For TB DOTS Package e. For Animal Bite Package feature to Day 0 ARV 1. For Newborn Care Package For Essential Newborn Care (c Interesting drying of newborn Entystic-to-akin connect g. For Cutpatient Ht/ADDS Treatme 3. Philihealth Benefits:	Inumsive Phase	le Code: ZO21F1	Note: Anti Rabies Vaccin RIG Newborn Screening Te	Emperation of the following sequences are a little for the following sequences and the following sequences are a sequences and the following sequences are a sequence and the sequences are a sequence are a sequence and the sequences are a sequence and the sequences are a sequence are a sequence and the sequences are a sequence are a sequence and the sequence are a sequence	adjuvant of adjuvant), "as indicated in the Z benefit package code"

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Accred	kation number/Name of kation No.: 1123	Accredited Health Care Pri	01-21		A	in to pay on top of	Detpis	ere kommenden der seind die der der der der der der der der der de	有 电磁性 描述 计对 指给 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	Tick this box if patient paid
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Accred	amiliani i-kipingkanapatakanan paki jer	gnature Over Printed Nam			and a	No co-pay on top of With co-pay on top c	Ffrithealth Henefit of Philiticalth Benefit	P	-Non-MAI	
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		ignature Over Printed Nam onth Say Tull L				With co-pay on top c	d Philbleaith Benefit	p		Professional fee
	PARTIII - CERT	IFICATION OF CON	SUMPTION OF	BENEFIT	S AND	CONSENT TO	ACCESS PATIE	NT RECORD/S		
	Philiseaith benefit k.enn	SUMPTION OF BENI ighto cover HCl and PFCh adictines, supplies, diagnos ution Fees	ter Chang.	ofessional fee	s by the r	Tol	iol Actual Charges" 0,000.00			Tick this box if patient has NO co- payment
		er/patient was complexely Ings/medicines, supplies,			enefit of	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	0,000.00 Lisnot completely con	Islamed Bij Twith		
	a) The total co-pay for t	he following are: Total Actual Charges*	Amount after App of Discount (i.e., p discount, Senlor Cit	Jersonal	Phi	Health Benefit	Amount ofter Ph	ill-tealth Deduction		Tick this box if patient has a co-payment
	Total Health Care Institution Fees Total Professional Fees for accredited and non-accredited professionals)	100,000.00		**************************************	100),000.00	Amount P Paid by (check all ti	nat applies): It		Patients admitted in basic or ward accommodation shall not be charged co-
	b.) Purchases/Expenses Total coat of purchases/ patient/member within Total cost of diagnostic within/outside the HET	s NOT included in the Heal is for drugs/medicines and viouside the HC during or /faboratory examinations during confinement harges should be based or	for medical supplies (minervent paid by the patient/m	cought by the		☐ None	Total Amount	P P		payment. Otherwise, indicate the amount if the patient has co- payment, as applicable
I herek efficies I herek which	y consent to the submis it processing of benefit; ey hold Philitealth or any i have voluntarily and w NA MAGTIBAY C	y of its officers, employees illingly given in connectio	and/or representati n with this claim for	es free from a vimbursemen	inyunda it before	ull legal liab/lities re Philifeoith.	elative to the herein-n			Affix signature of the patient/parent /authorized representative
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Annex J.3: Sample CF2 for Chemotherapy

SAMPLE CLAIN	л FORM 2 FOR CH	EMOTHERAPY		This form may be reproduced and		
PhilHealth	Catyria Call Cente	Republic of the Philippenes ALITH INSURANCE COR. a Centra 709 Show Boulevard, Pacin City (92) 441-7422 • Trankline (92) 441-74 www.philheath.gov.ph add. action.comter@philiheath.gov.ph		is not Form SALE CF 2 (Claim Form 2) Revised September 2018	- 1	Date of the
	LAND CHECK THE APPROPRIATE BOX		Series # [][]		С	nitial chemotherapy session
All information, fields and trick box	is required in this form are necessary. 6 4 OR MIS REPRESENTATION SHALL E	Jain forms with incomplete information: IE SUBJECT TO CRIMINAL, CIVIL GRAD CARE INSTITUTION (HCI) INI	chall not be processed. MINISTRATIVE DABILI ORMATION	ies.	c	Date of the end cycle or in case of lost to
	n Number (PAN) of Health Co ABCDF Medic Altution:	al Center	XXXX		f	ollow-up or leath, indicate
3.Address:	SHAW BLVD uilding Number and Street Name	PASIG CITY CityMunicip	entener visikanaa kuussississa kanaan ka Kanaan kanaan kanaa	PYDVITCE	l t	he last cycle given to the
	PART II - PAT DELA CRUZ	IENT CONFINEMENT INFOR	MATION	I MAPAGPALA		patient
1.Name of Patient:	Last Name	First Harne	Name Extension (#g/SR/N)	Middle Name (ox: DELACRUZ JAM) JRSJPAG		Write
M NO IT TES	another Health Care Institu		17 - ^+~min fr v van 9 ma fr v 28 m2 fr 20 20 fill fill fill fill fill fill fill fil	- New Years for the Security of Security o	₽ i	OUTPATIENT in lieu of time admitted &
No. 3. Confinement Period:	me of referring Neelth Care Institution a. Date Admitted: (013 - 13 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1-12.0.2.4,		Province Zip code	ľ	discharged
4. Patient Disposition: (self a. Improved b. Recovered c. Home/Discharged A d. Absconded	e. Expired I Transferre painst Medical Advise Recover/s	104(11) Carl Valle Valle	Time: Landon I have to of Refered House Level to	PRAGA	 	Fick YES if the patient was referred by another HF
6. Admission Diagnosis/es 7. Discharge Diagnosis/es Diagnosis Breast Cancer	Use additional CF2 if necessary):	TO'S OF CHICK'S CHILD	Cote of Procusture	Laterality (check applicable book left right both left right both	ti ti p	This is not required, as reatment provided is an out-patient setting
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Annex J.4.1: Sample CF2 for Hormonotherapy Tranche 1

SAMPLE CLAI	M FORM 2 FOR HO	RMONOTHERAF	Y TRANCHE 1	This form may be reproduced and		
PhilHeal Tour Porture in Heads	Crystat Call Center	Republic of the Philippines ALITH INSURANCE C Centre 709 Share Houlevard, Pasi (02) 441-7442 * Trunkline (02) www.philine.ht.gor.ph all ectorncenter@philipealth.gor.ph	g City 441-7444	is NOT FOR SALE CF-2 (Claim Form 2) Revised September 2018		Date of the 1st month of
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Annex J.4.2: Sample CF2 for Hormonotherapy Tranche 2

SAMPLE CLA	AIM FORM 2 FOR HO	RMONOTHERA	PY TRANCHE 2	This form may be reproduced and	-	
C Philhea Nous Parties II. 19	III Citysta nuth Call Cente	Republic of the Philippines ALTH INSURANCE (te Centre 709 Show Boulevard, Pase (02) 441-7442 • Trunkline (02) www.philhealth.gov.ph natk actioncenteral/philhealth.gov.p	ig City) 441-7484	IS NOT FOR SALE CF-2 (Claim Form 2) Revised September 2018		
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PART IV - CERTIFICATION OF CONSUMPTION OF HEALTH CAREINSTITUTION Affix			
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Annex J.6: Sample CF2 for Surveillance

SAMPLE CLAIM	FORM 2 FOR SU	RVEILLANCE		This form may be reproduced and	<u> </u>
PhilHealth New Partner in Houlds	Citysta Call Cente	Republic of the Philippines ALTH INSURANCE; te Centre 709 Shaw Bouleverd, Pu w (02) 441-7442 • Trunkline (6: www.philheuth.gov.ph mail: actionocenter@philheuth.gov.	zig City 2) 441-7444	es NOT FOR SALE (Claim Form 2) Rovised September 2018	Indicate the
IMPORTANT REMINDERS: PLEASE WRITE IN CAPITAL LETTERS AN This form together with other supports All information, fields and trick boxes or FALBERINCORRECT INFORMATION O	ng doxuments should be filed with Equired in this form are necessary. R MISREPRESENTATION SHALL	in sixty (60), calender deys from di Claim forms with incomplete into	rmation shall not be processed. LOR ADMINIST RATIVE LIABILIE	TES.	date of the procedure was done
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4. Type of Accomodation: 6. Admission Diagnosis/es: 7. Discharge Diagnosis/es (Me	Breast Cancer and disord CF2 if necessary:	to (Chanty Service)			This is not required as treatment provided is an out-patient
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a. For the following repetitive prod Hemodialysis Peritoneal Dialysis		Carl	Transhainer Indonesia	Otherapy, see guisdines,	Indicate the diagnosis
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d. For TB DOTS Package e. For Animal Bitte Package ferrite to bay 0 ARV f. For Newborn Care Pickage For Essential Newborn Care if Immediate drying of newborn Eurlystic-taskin contact g. For Outpatient (RMADS Treatme	be dates [mm-dd-yess] when the final state of the final state of the control of t		RIG Newborn Screening Te BGG versimking	Secure on a contract you and the secure of the contract of the	
9.PhilHealth Benefits:	ALLEN AL	The state of the s			
ICO 10 or RVS Code: 4. See E.	ng gay Dadiga Managanan ayan mada ka ayan ayan ayan ayan ayan ayan ayan	a man anadora minjana per mengapi ti kalaha man anamanang pagangap pelabumanan pagangan pang may	L. Second Case Rate	hada aanay 19 (1999 k. h.). hiila di sahaan y 1989 (1991 h.) di baaqaanay aayay 19 kkal bayaayaa sayay 19 yahii ba	<u></u>

	oditation Number/		l Health Care Professions	l/D	ate Signed and Prof	essionat Fees/Charges		
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		ignature Over Printed Nam			With co-pay on top of	Priffically Benefit P		Professional
	Date Signed: L	oler Filolog Filologic	-					fee
Accrec	fication No.: L.L.		LLJ-LLJ	r	***		L	
	S	ignature Over Printed Ham		Į.	No co-pay on top of F	hilfimith Benefit Philfimith Benefit P		
	Date Signed: L			L.	anni raduak rucceb tu	[C. S.	Ī	Tick this box
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		ignature Over Printed Nam	· ·		With co-pay on top of	f Philifealth Benefit P	_	Professional
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	purchases/expenses for	urpatanus completely drugs/medicines, supplies	consumed pear to us pay on one diagnostics and others.	Lie s (stit of the castrook betient	is not completely consumed BUT with	1	
	a.) The total co-pay for	the following are:					Ìſ	Tick this box
		Total Actual Charges*	Amount alter Application of Discount (i.e., personal discount, Senior Citizen/PWD)		Philhealth Benefit	Arrount after Philifealth Deduction		if patient has a co-payment
			Accommendate to the second of the second	-		Amount P 0.00		•
	Total Health Care Institution Fees	2,700.00			2,500.00	Paid by (check all that applies): Hember/Patient HMO Others 8 c., PCSO, Promisory note, etc.	<u> </u>	
	Total Professional			********	Militar or or remainder commercia sees in 1974 of the first of the first or commencial sees,	Amount P		
	Fees for accredited and non-accredited					Pald by tcheck all that applies: Member Patient HMO	İ	Indicate the
	budesiousy)					Cithers i.e., PCSO, Promisory note, etc.		amount if the
	b.) Purchases/Expense	s NOT included in the Hea	Uh Care Institution Charges	Menistratus			 >	patient has co- payment, as
	patient/memberwith	n/putside the HCl during a			[] None	Total Arrount, P	Post of the Control o	applicable
	Total cost of diagrostic within fautaide the HCI		paid by the patient/member done	Ŷ	☐ None	Total Amount P		
	* NOTE: Total Actual C	narges alvould he besed or	n Statement of Account (SCA)	Nada-o		And the second s		
B.CON	SENT TO ACCESS P	ATIENT RECORD/S:			<u>.</u>		Γ	Affix signature
l berei	by consent to the submis	:sion and examination of t	the patient's pertinent medical re	cord	Sorthe purpose of verify	ring the veracity of this claim to effect		of the
efficie Lhora	nt processing of benefit	payment. und its officers, constructor	Acolor representativa e fraz feni	. Phys. c	Stational limbilisies es	lative to the herein-mentioned consent		patient/parent
which	i have voluntarily and s	villingly given in connectic	n with this claim for reimbursem	eat t	reford Philitealth.	When a see had have seen the seed that the seen that		/authorized
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	Date Signed: L	0,8,-,3,0,-,2,0	.2.4. Job		is unable to write, p right thumbmark, F	Patient/		Indicate date
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	ember/patient:	O Salbatoria C		/				
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Signet	ure Over Printed Name o	f Authorized HQ Repasent	ative Official Cap	encity The second	//Designation	RECEIP TO YOUR		•

Annex K: Pathway of the Benefits Availment of the Z Benefits for Breast Cancer



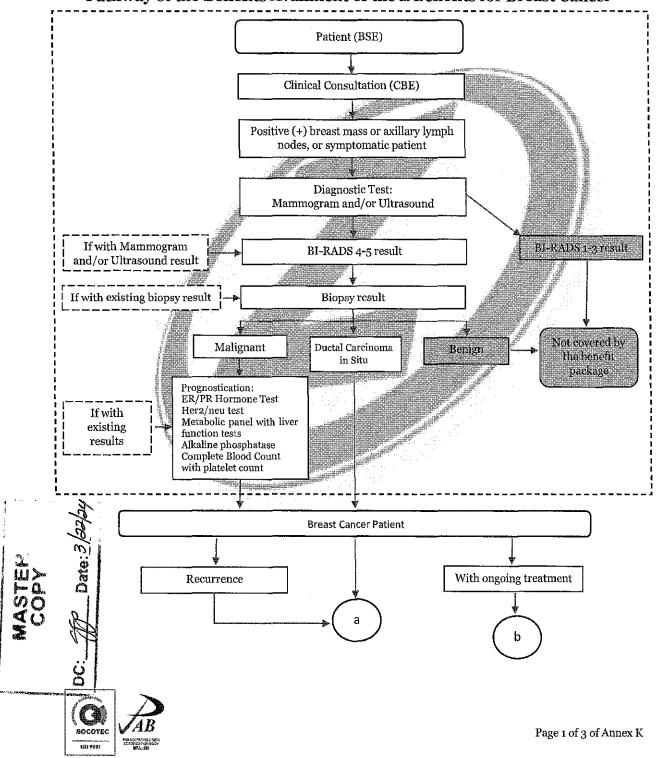


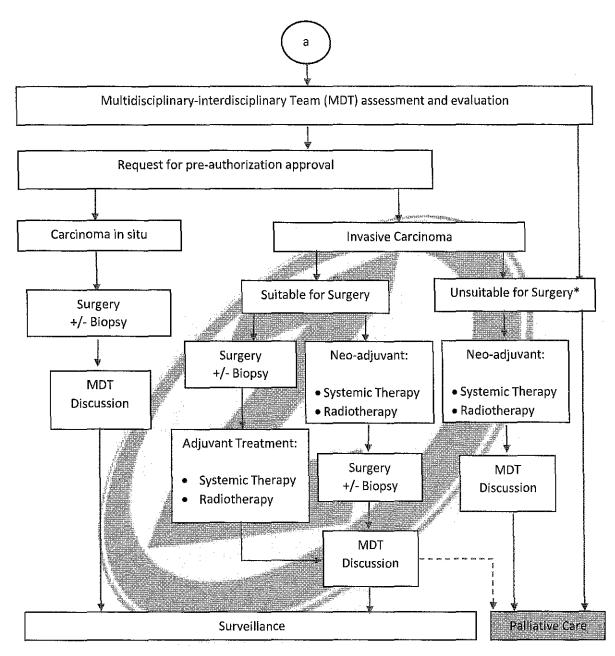
Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

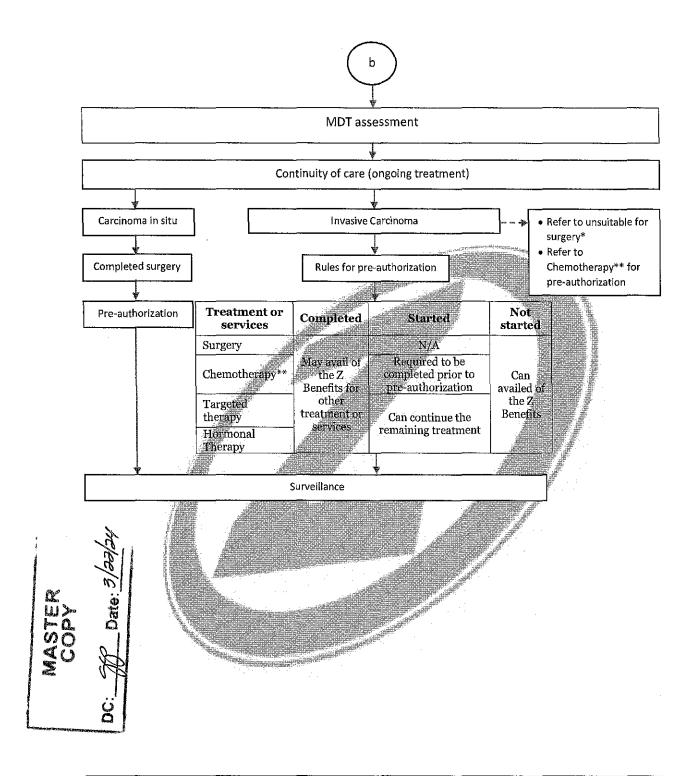
- Citystate Centre, 709 Shaw Boulevard, Pasig City
- **६** (02) 8662-2588 ⊕ www.philhealth.gov.ph
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Pathway of the Benefits Availment of the Z Benefits for Breast Cancer









Disclaimer: The algorithm may change in accordance with the updates on the Clinical Practice Guidelines. The Z Benefits for Breast cancers covers treatments and services that are included in the benefits package. Other rules are indicated in the PhilHealth Circular

Annex L: Breast Cancer Treatment Protocols





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Breast Cancer Treatment Protocols

Legend:

A – Doxorubicin	T – Docetaxel
C – Cyclophosphamide	Pacli – Paclitaxel
H – Trastuzumab	Cb – Carboplatin
Tamox - Tamoxifen	Anas – Anastrozole
Zola – Goserelin	Letro - Letrozole

1. For Stage IA and above: hormone receptor (ER/PR) positive and HER2 positive BRCA

	PREMENOPAUSAL
OPTIONS	REGIMEN
A	AC x 4 cycles → TH x 4 cycles → H x 14 cycles → Tamox +/- Zola x 5 years
B. 10.	AC x 4 cycles → Pacli x 12 weeks + H x 18 cycles → Tamox +/- Zola x 5 years
C	TCbH x 6 cycles → Tamox +/- Zola x 5 years

45	POSTMENOPAUSAL
OPTIONS	REGIMEN
	AC x 4 cycles \rightarrow TH x 4 cycles \rightarrow H x 14 cycles \rightarrow Anas/Letro x 5 years
E	AC x 4 cycles → Pacli x 12 weeks + H x 18 cycles → Anas/Letro x 5 years
F	TCbH x 6 cycles → Tamox +/- Zola x 5 years

2. For Stage IA with tumor </= 0.5cm → hormone receptor (ER/PR) positive and HER2 negative BRCA

	PREMENOPAUSAL
OPTION	REGIMEN
G	Tamox +/- Zola x 5 years

	POSTMENOPAUSAL	
OPTION	REGIMEN	
Н	Anas/Letro x 5 years	



3. For Stage IA and above with tumor > 0.5cm \rightarrow hormone receptor (ER/PR) positive and HER2 negative BRCA

	PREMENOPAUSAL
OPTIONS	REGIMEN
I	AC x 4 cycles \rightarrow T x 4 cycles \rightarrow Tamox +/- Zola x 5 years
J	AC x 4 cycles \rightarrow Pacli x 12 weeks \rightarrow Tamox +/- Zola x 5 years

	POSTMENOPAUSAL
OPTIONS	REGIMEN
K	AC x 4 cycles \rightarrow T x 4 cycles \rightarrow Anas/Letro x 5 years
L	AC x 4 cycles \rightarrow Pacli x 12 weeks \rightarrow Anas/Letro x 5 years

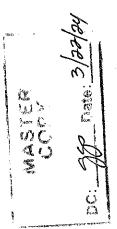
4. For Stage IA and above \rightarrow hormone receptor (ER/PR) negative and HER2 positive BRCA

OPTIONS	REGIMEN
M	AC x 4 cycles \rightarrow TH x 4 cycles \rightarrow H x 14 cycles
N	AC x 4 cycles → Pacli x 12 weeks + H x 18 cycles
O	TCbH x 6 cycles

5. For Stage IA and above with tumor >0.5cm → hormone receptor (ER/PR) negative and HER2 negative BRCA

ODUNTOR	REGIMEN
OPTIONS	KEGIMEN
_	
P	$AC \times 4 \text{ eveles} \rightarrow T \times 4 \text{ eveles}$
	$AC \times 4$ cycles \rightarrow Pacli x 12 weeks
	ASSISTACION TOUR ALL WOOLD

Disclaimer: The Breast Cancer Treatment Protocols are based on the Clinical Practice Guidelines that may be subjected to changes or updates. The Z Benefits for Breast Cancer covers treatments and services as defined in the mandatory services of the benefits package.



Annex M: Breast Cancer Medical Records Summary Form





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HEALTH FACILITIES (HF)	
ADDRESS OF HF	
A. PATIENT 1. Last Name, First Nar	ne, Middle Name, Suffix SEX ☐ Male ☐ Female
2. PhilHealth ID Numb	oer 00-000000-0
"same as above")	patient is a dependent; otherwise, write, me, Middle Name, Suffix per
BREAST CANCER MED	DICAL RECORDS SUMMARY FORM
up1" patients in contracted health faci	for all breast cancer mortalities and "lost to follow- lities. Completely fill-out all required items. Submit the specific treatment phase, as applicable.
Laterality of breast cancer (Choose	Right
one by ticking the appropriate box)	Left
one of the state o	Both
	□ Not recorded in the chart
Biopsy Histological Diagnosis (Verbatim from histopathology report)	
Date of biopsy	Date (mm/dd/yyyy)
Clinical Cancer Stage at pre-	☐ cStage o
authorization (Choose one by	CStage IA
ticking the appropriate box)	☐ cStage IB
	☐ cStage IIA
rec	☐ cStage IIB
3	☐ cStage IIIA
Dele. 3 Jan	☐ cStage IIIB
21	☐ cStage IIIC
	☐ cStage IV
	☐ Not recorded in the chart



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

Date of post-surgical	(mm/dd/yyyy)		
histopathologic report			
Histological/nuclear grade	GX: Grade cannot be assessed		
(Choose one by checking the	(undetermined grade)		
appropriate box)	G1: well-differentiated (low grade)		
	G2: moderately differentiated (intermediate		
	grade		
·	G3: poorly differentiated (high grade)		
	G4: undifferentiated (high grade)		
	Not recorded in the chart		
Dull lesial Course State (Chance			
Pathological Cancer Stage (Choose	cStage o		
one by checking the appropriate	cStage IA		
box)	□ cStage IB		
	☐ cStage IIA		
	☐ cStage IIB		
	☐ cStage IIIA		
	☐ cStage IIIB		
	☐ cStage IIIC		
	□ cStage IV		
	Not recorded in the chart		
Provide the appropriate	What is T?		
information for TNM	What is N?		
	What is M?		
	Not recorded in the chart		
Widest diameter of primary tumor	(cm) or (mm)		
Tridest diameter of primary turner	Not recorded in the chart		
Number of positive lymph	positive lymph nodes		
nodes/TLNs harvested	TLNs		
liotos, 12115 Har vostoa	☐ Not recorded in the chart		
Lymphovascular invasion (Choose	☐ Negative		
one by checking the appropriate	Positive		
box)	☐ Not recorded in the chart		
Perineural invasion (Choose one by			
checking the appropriate box)	Positive		
	Not recorded in the chart		
Surgical margin involvement	☐ Negative		
(Choose one by checking the	Positive		
appropriate box)	Not recorded in the chart		
Were tumor markers done?	Yes		
(Choose one by checking the	□ No		
appropriate box)	Not recorded in the chart		
ER	☐ Negative		
(Choose one by checking	Positive: _% (1% to 100%); Alfred score		
the appropriate box)	Not recorded in the chart		
PR	Not recorded in the chart Negative		
(Choose one by checking			
r ₁ -	Positive: _% (1% to 100%); Alfred score		
the appropriate box)	Not recorded in the chart		

Heraneu IHC staining intensity	Negative			
(Choose one by checking the	Positive			
appropriate box)	Equivocal			
	Not recorded	Lin the chart		
Haveney cone				
Her2neu gene	Non-amplifie	30		
amplification (Choose	Amplified			
one by checking the	Not recorded	l in the chart		
appropriate box)				
		·		
I. Breast Cancer Treatment Prof				
Was definitive surgery done? (Choose	7			
by checking the appropriate box)	□ No			
	☐ No op	erative record in the chart		
If yes, what is the name of the surgica				
procedure?				
Was chemotherapy given in the	Yes			
contracted health facilities? (Choose	□ No	The state of the s		
one by checking the appropriate box)		cord found in the contracted		
	. —	health care institution		
	ĭ	Chemotherapy was given by another		
		healthcare provider		
If answer to previous question is "no,	∟ Patien	t preference		
check the appropriate box and must				
provide details.				
		ed by healthcare provider		
·	Dotion	t is "lost to follow up!"		
	Fatien	t is "lost to follow-up¹"		
If answer is "yes," specify the drug				
regimen				
used.				
Specify the total dose per cycle for the	Total	dose per cycle:		
drug regimen used (Choose one b		1		
checking the appropriate box)		ecorded in the chart		
If chemotherapy was given, provide t		dd/yyyy		
date when chemotherapy start		ecorded in the chart		
appropriate box)	LINA, C	hemotherapy was not given		
If chemotherapy was given, how man				
If chemotherapy was given, how mar cycles were given? (Choose one by checking the appropriate box)		hamathanany yaras mat airean		
checking the appropriate box)		chemotherapy was not given		
1 70				
K.				

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Page 4 of 7 of Annex M

Adjuvant
☐ Neo-adjuvant ☐ NA, chemotherapy was not given
☐ NED (no evidence of disease
progression)
CR
□ PR
☐ PD (progressive disease) ☐ Not recorded in the chart
NA, chemotherapy was not given
No
Not recorded in the chart
NA, chemotherapy was not given
Adverse event to former chemotherapy.
Specify adverse event:
ПРО
· =
☐ Patient preference☐ Other (Specify):
Not recorded in the chart
NA, chemotherapy was not given
MA, chemotherapy was not given
Total dose per drug per cycle:
☐ Not recorded in the chart
☐ Not recorded in the chart mm/dd/yyyy
mm/dd/yyyy
mm/dd/yyyy
mm/dd/yyyy Adjuvant Neo-adjuvant
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart NED
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart NED CR
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart NED CR PR
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart RED CR PR SD
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart NED CR PR
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart RED CR PR SD
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart RED CR PR SD PD
mm/dd/yyyy Adjuvant Neo-adjuvant Palliative Not recorded in the chart CR PR SD PD Not recorded in the chart

If RT was advised, was radiotherapy	Yes, it is recorded in the chart
given?	No, it is recorded in the chart
	It is not documented in the chart
Was supportive care given?	Yes, it is recorded in the chart
	No, it is recorded in the chart
	☐ It is not documented in the chart
If answer is "yes," specify supportive care	Pain control (Specify):
(May choose more than one)	☐ Nutrition build-up
	Rehabilitation from a sequela
	of the treatment
	Psychological counseling
	Psychiatric intervention
	Religious/faith counseling
	Referral to Civil Society Organization
	NA, supportive care was not given
	☐ NA, it is not documented in the chart
Was the hormonotherapy given to the	Yes
contracted health facilities? (Choose one	□No
by checking the appropriate box)	No record was found in the
	contracted
	health facility
	☐ Hormonotherapy was given by
	another
	healthcare provider
If the answer to the previous question is	☐ Patient preference
"no," check the appropriate box and must	Advised by a healthcare provider
provide details.	Advised by a heatthcare provider
	☐ Patient is "lost to follow-up¹"
If the answer is "yes," specify the drug	
regimen	
used.	
Specify the total number of prescriptions	☐ Total prescription:
for the drug regimen used (Choose one by	
checking the appropriate box)	☐ Not recorded in the chart
If hormonotherapy was given, provide the	mm/dd/yyyy
date when it was started (Choose one by	Not recorded in the chart
checking the appropriate box)	☐ NA, hormonotherapy was not given
What is the purpose of hormonotherapy?	Premenopausal
(Choose one by checking the appropriate	Postmenopausal
box)	NA, hormonotherapy was not given
Was the targeted therapy given to the	☐Yes
contracted health facilities? (Choose one	□No
by checking the appropriate box)	☐ No record found in the contracted
	health facility

MASTER COPY C: # Date: 3/34/

		☐ Targeted therapy was given by
		Another healthcare provider
	If answer to previous question is "no,"	Patient preference
	check the appropriate box and must provide details.	Advised by healthcare provider
		Patient is "lost to follow-up1"
	If answer is "yes," specify the drug regimen used.	
	Specify the total dose per cycle for the	Total dose per cycle:
	drug regimen used (Choose one by checking the appropriate box)	☐ Not recorded in the chart
	If targeted therapy was given, provide the	mm/dd/yyyy
	date when it was started (Choose one by	☐ Not recorded in the chart
	checking the appropriate box)	NA, targeted therapy was not given
	If targeted therapy was given, how many cycles were given? (Choose one by checking the appropriate box)	☐ NA, targeted therapy was not given
	III.Breast Cancer Survival Status	
		mm/dd/yyyy
	What is the status of this patient at this date	Alive
		Died
		Lost to follow-up ¹
	777	Not recorded in the chart
	When was date of last follow-up?	☐ mm/dd/yyyy ☐ Not recorded in the chart
	What is the status of this patient at this	☐ Alive, NED
	last follow-up date?	Alive with residual small lesions, on
T-MATERIAL STATE	31	definitive treatment
	E .	Alive with residual small lesions, without
		definitive treatment
		Alive with residual big lesions, on
.	5.	definitive treatment
)		Alive with residual big lesions,
d.		without definitive treatment
		Alive with terminal disease, only on
	45	supportive treatment
ण्याले ध् रतासाका	£2	Not recorded in the chart
	If died, when was date of death?	mm/dd/yyyy Not recorded in the chart
	If died, what is cause of death?	Breast cancer-related
	If died, what is cause of death?	Breast cancer-related Not cancer-related
	If died, what is cause of death?	

Page 7 of 7 of Annex M





Annex N: Outcome Indicators

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OUTCOME INDICATORS FOR BREAST CANCER

I. Cancer detection rate

- A. Clinical Breast Examination
 - 1. Interval palpable breast mass found
- B. Mammography
 - 1. Interval BIRADS 4-5 breast lesion found
- C. Breast Ultrasound
 - 1. Interval BIRADS 4-5 breast lesion found
- D. Biopsy
 - 1. Confirmed breast cancer (n)
 - 2. Cancer detection rate (%)
 - 3. Time interval from Screen to Biopsy at initial diagnosis

II. Cancer Stage at Diagnosis (defines prognosis)

III. Molecular Profile at Diagnosis (defines prognosis)

- A. ER+ (%)
- B. PR+ (%)
- C. HER2neu+(%)

V. Time interval from confirmed breast cancer to start of

- A. Neoadjuvant anti-cancer drug treatment
 - B. Definitive surgery (e.g.Mastectomy)
 - C. Adjuvant anti-cancer drug treatment
 - D. Radiotherapy

•V. Anti-cancer Treatment Complication (surgery complication, anti-cancer drug adverse effect, radiotherapy adverse effect, worsening of comorbidity)





VI. Compliance rate (%) (Completed, deferred due adverse effect, lost to follow-up/abandonment)

- A. Surgery
- B. Cytotoxic drug therapy
- C. Targeted drug therapy
- D. Radiotherapy
- E. Hormonal drug therapy

VII. Disease Progression rate (%Recurrence; % Distant metastasis occurrence)

VIII. Survival / Mortality rate (% alive; % died within a defined time period)



Annex O: Guide on Co-payment Proposal of the Z Benefits Package for Breast Cancer





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Guide on Co-payment Proposal of the Z Benefits Package for Breast Cancer

At Point of Services	Co-payment Rules
Diagnostic Tests and Prognostication	Not to exceed the line item equivalent of the package rate
Surgery	Not to exceed the package rate; No co-payment in basic or ward accommodation
Chemotherapy	Not to exceed the package rate per cycle
Hormonotherapy (2) Tranches	Not to exceed the package rate per monthly prescription
Targeted Therapy (3) Tranches	No co-payment
Surveillance	Not to exceed the line item equivalent of the package rate

Note: The co-payment proposal for each of the services or treatment phases of the Z Benefits package for breast cancer is subject to negotiation and approval of PhilHealth. The negotiated co-payment shall be stipulated in the contract of the health facility.

