Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PHILHEALTH CIRCULAR
No. 2024 - 0035

TO : ALL CONTRACTED HEALTH FACILITIES FOR THE Z BENEFITS PACKAGE FOR KIDNEY TRANSPLANTATION, AND OTHERS CONCERNED

SUBJECT : Z Benefits Package for Kidney Transplantation

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I. RATIONALE

Chronic kidney disease (CKD) is a pressing global health issue, with prevalence of 9.1% to 13.4% of the population worldwide.[1] In the Philippines, its prevalence is 35.94%, which is much higher than estimated global rates.[2] According to the National Kidney and Transplant Institute (NKTI), one Filipino develops chronic kidney failure every hour, equating to around 120 new cases per million population annually.

In 2012, PhilHealth launched a comprehensive benefits package for kidney transplantation (low risk) under the Z Benefits. With the enactment of Republic Act (RA) No. 11223, or the Universal Health Care (UHC) Act, portions of the funds from the Philippine Amusement and Gaming Corporation (PAGCOR) and Philippine Charity Sweepstakes Office (PCSO) shall be transferred to PhilHealth for the improvement of benefits packages.

Kidney transplantation[3] is the gold standard treatment among the renal replacement therapies for patients with chronic kidney disease stage 5 (CKD5).

Thus, the PhilHealth Board of Directors, through Board Resolution No. 2964 s. 2024 approved the enhancement of the Z Benefits package for kidney transplantation. This enhancement not only aims to increase access to transplantation but also ensure that patients receive holistic, continuous, and high-quality treatment for pre- and post-operative transplantation care.

II. OBJECTIVES

This PhilHealth Circular aims to expand the coverage for kidney transplantation, including deceased organ donation, and ensure equitable access to quality healthcare services and financial risk protection.

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC9073222/
[2] https://pmc.ncbi.nlm.nih.gov/articles/PMC8880400/#pone.0264393.ref002
[3] https://pubmed.ncbi.nlm.nih.gov/37955463/

III. SCOPE

This PhilHealth Circular shall apply to all contracted health facilities (HFs), PhilHealth Regional Offices (PROs), Local Health Insurance Offices (LHIOs), and other institutions involved in the implementation of the Z Benefits Package for Kidney Transplantation.

IV. DEFINITION OF TERMS

A. **Balance Billing**[4] – refers to the additional payments by insured patients on top of the amount paid by insurance when the provider's charges exceed the amount covered by health insurance. Due to financial and service coverage decisions, balance billing may result in increased financial burdens and limited access to health services by households.

B. **Basic or ward accommodation** - refers to the provision of regular meal, bed in shared room, fan ventilation, shared toilet and bath. No other fees or expenses shall be charged to patients admitted in basic accommodation. Special beds, as defined in this PhilHealth Circular shall be treated as basic or ward accommodation for kidney transplantation recipients.

C. **Case-based Provider Payment Mechanism** – refers to a provider payment system in which a health facility is reimbursed at a predetermined rate for each of the treatment phases or services rendered during the medical treatment given to an individual.

D. **Chronic Kidney Disease Stage 5 (CKD5)** – refers to end-stage renal disease (ESRD) or an advanced stage of kidney disease resulting in irreversible loss of nearly all ability to remove toxic by-products from the blood.

E. **Contracted Health Facility (HF)**[5] – refers to any health facility that enters into a contract with the Corporation for provision of specialized care.

F. **Copayment** – 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 upgrade of services beyond the coverage of the benefits package. Copayments shall have a fixed limit or cap not exceeding the corresponding rate of the Z Benefits package. These copayment rates shall be subject to negotiation by PhilHealth and stipulated in the contract to determine the applicable rates and ensure financial risk protection for the beneficiaries.

G. **Cost-sharing** – refers to the direct payment of a portion of health care costs by the members/dependents when receiving health services. This term generally includes coinsurance, copayment, or similar charges.

H. **Essential Health Services** – refer to a set of identified lists of services that PhilHealth covers for which HFs must provide based on clinical practice guidelines

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[4] PC No. 2024-0023: Institutionalization of 156 Hemodialysis Sessions and Coverage Expansion (Revision 2)
[5] PC No. 2022-0012: Contracting of a Health Facility as a Z Benefit Provider (Revision 1)

(CPG) and/or expert consensus as approved by the Corporation. These include room and board, drugs and medicines, staff time, laboratory, diagnostic tests, and monitoring procedures, and general supportive care.

I. **Kidney Transplantation (KT) Data Registry** – refers to a comprehensive system designed to collect, store, and analyze data related to kidney transplant and organ donation to improve patient care, optimize outcomes, and support research and policy making.

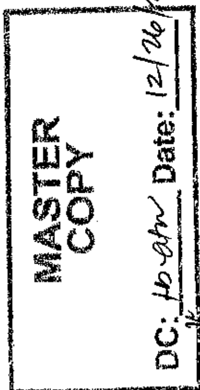
J. **Member Empowerment (ME) Form** – refers to a document showing that the patient is fully informed of their Z Benefits package, treatment options, treatment schedule and follow-up visits, roles, and responsibilities. The ME Form also documents that the contracted health facility provided education, 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.

K. **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.

L. **Postoperative Complications** - refers to events that occurred within 30 days after surgery.

M. **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.

N. **Reference Health Facility** - refers to a contracted health facility where, in addition, shall provide technical and administrative services, such as but not limited to, the creation and maintenance of a patient or data registry, costing and procurement of agreed mandatory services, setting of standards of care and capacity building of prospective contracted health facility.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O. **Renal Replacement Therapy** – refers to kidney replacement therapy which is a medical treatment that replaces the normal kidney function in patients with acute or chronic kidney failure. It involves using various techniques, such as hemodialysis, peritoneal dialysis, and kidney transplantation, to remove waste products, excess fluids, and electrolytes from the bloodstream.

P. **Reverse (Protective) isolation**[6] – refers to a method used in healthcare institutions for patients with increased susceptibility to infections, such as organ transplantations, cancer treatments, premature newborns, extensive burns and other immune-impaired patients.

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[6] https://www.researchgate.net/publication/331336329_Protective_Isolation_Practice_and_Theory

Q. **Special Bed**[7] – refers to an accommodation with additional fixtures and amenities that are essential to the provision of specialty care of patients, which includes, but are not limited to, critical care units, intensive care units, and isolation rooms.

V. POLICY STATEMENTS

A. Benefits Availment

1. All Filipinos are automatically entitled to avail of this benefits package. PhilHealth beneficiaries shall comply with the existing membership eligibility guidelines.

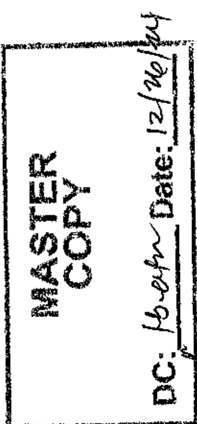
2. All CKD5 patients who meet the clinical criteria shall be eligible to avail of the Z Benefits for kidney transplantation with living (related or non-related) or deceased organ donors. The selection criteria are detailed in the Pre-authorization Checklist and Request Form (Annex A), which shall serve as the basis for PhilHealth's approval.

3. PhilHealth shall contract capable accredited health facilities (Refer to Annex B: Supplementary Rules on Contracting HFs) to provide the essential health services (Annex C) for the Z Benefits package for kidney transplantation (living and deceased organ donor).

4. The contracted HFs shall submit the pre-authorization for patients with living (related or non-related) organ donors to PhilHealth for approval before availing of the benefits package. The approved pre-authorization shall be valid for a period of sixty (60) calendar days.

5. Pre-authorization request for KT procedure involving deceased organ donor shall be submitted to PhilHealth within two (2) working days after completion of the surgical operation.

6. The designated liaison of the contracted HF shall submit the properly accomplished original copy of the Pre-authorization Checklist and Request Form and Member Empowerment (ME) Form (Annex D), including the MDT plan, to the 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.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7. This benefits package covers medical services for both donor and recipient, such as pre-transplantation evaluation and surgical procedures related to kidney transplantation of recipient candidates utilizing either a living organ donor (related or non-related) or a deceased organ donor, including coverage of donor management, donor nephrectomy and organ preservation.

8. All KT patients shall be registered in the Kidney Transplantation (KT) Data Registry as part of the requirements to avail of the benefits package. Registry data

[7] DOH AO No. 2021-0015: Standards on Basic and Non-Basic Accommodation in All Hospitals

shall be submitted at pre-specified intervals including post-transplants monitoring, as a requirement for renewal of contracting for the Z Benefits

9. The forty-five (45) day annual benefit limit shall not apply when a patient avails of this benefits package.

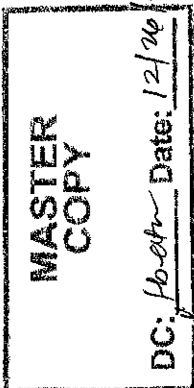
10. The contracted HF shall discuss the ME Form with the patient, including an explanation of the cost-sharing aspect of the benefits package. Its primary purpose is to empower patients to actively participate in healthcare decision-making by providing them with essential information and education regarding their health condition and available treatment options.

11. The contracted HFs shall not charge copayment for essential health services (Annex C) and postoperative complications for kidney transplant donors admitted in basic or ward accommodation[8] or for kidney transplant recipients admitted in special beds such as reverse isolation rooms.

12. The contracted HF may charge copayment or out-of-pocket (OOP) payment for services that are not included in the list of essential health services (Annex C) and amenities that are provided to the patient but are not covered by the Z Benefits package. This copayment is mutually agreed by the patient and contracted HFs during the discussion of the ME form for services beyond the scope of essential health services.

13. Patients who have availed of the Z Benefits package for kidney transplantation shall be eligible to avail of the hemodialysis package, whether temporary or permanent dialysis, in cases of graft failure due to acute or chronic rejection or infection, acute kidney injury, or other medical conditions or complications that may necessitates the patient's return to dialysis.

14. PhilHealth shall reimburse drugs listed in the latest edition of the Philippine National Formulary (PNF). PhilHealth reiterates the mandate of the Health Technology Assessment, which provides positive recommendation for any proposal to cover drugs, medicines, or biologicals not listed in the latest Philippine National Formulary (PNF), new health technologies, surgical procedures, and other treatment interventions.



B. Responsibilities of the Contracted Health Facilities

1. The contracted HFs shall obtain informed consent from both donor and recipient, adhere to the selection criteria, and provide education on the risks, benefits, and post-procedure care, including potential complications and long-term management.

2. The organ transplant procedure shall follow the ethical guidelines[9] and comply with all relevant laws, rules, and regulations on voluntary organ donation (living or deceased).

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[8] DOH AO No. 2021-0015: Standards on Basic and Non-Basic Accommodation in All Hospitals

[9] DOH AO No. 2021-0059: Guidelines on Ethical Organ Donation and Transplantation from Living Donors

3. The Multidisciplinary-interdisciplinary team (MDT) shall be composed of the following:

   a. Attending Nephrologist
   b. Transplant Surgeon
   c. Urologist (except for KT procedures involving a deceased organ donor)

4. The MDT shall conduct a comprehensive medical evaluation of the donor and the recipient before enrolling patients under the Z Benefits. They shall submit a treatment plan that includes details of the patient's condition, pre-transplant evaluation, surgical procedure, and post-transplant care.

5. The contracted HF shall manage any postoperative complications of kidney transplantation such as infections, bleeding, organ rejection, delayed graft function, or side effects from medications.

6. The contracted HFs shall ensure equitable allocation of all deceased organ donations, establish a non-commercial process of availment, and follow the clinical standards guidelines of organ preservation or best practices for the proper handling, cooling, and timely retrieval of organs to maintain their viability for transplantation.

7. The contracted HFs must ensure patient compliance with regular clinic visits, medication, and other measures to promote optimal health outcomes.

8. The contracted HFs shall not balance bill any patient beyond the amount prescribed in the benefits package for covered services. In cases of copayment, the contracted HF shall not charge the patient more than the agreed copayment at the point of service.

9. The contracted HFs shall appoint at least one (1) Z Benefits Coordinator, whose responsibilities are outlined in PhilHealth Circular (PC) No. 2021-0022 " The Guiding Principles of the Z Benefits (Revision 1)."

10. The contracted HFs shall maintain a digital or physical copy of all medical records for monitoring and post-audit purposes by PhilHealth.

11. As stipulated in the Universal Healthcare Act, Chapter IV, Sec. 18 (b), there shall be no differentiation between facility and professional fees (PF). PhilHealth shall credit all payments to the accounts of contracted private and public HFs.

C. Benefits Packages for Kidney Transplantation in Adult and Pediatric Patients

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1. Living Organ Donor Transplantation using Basiliximab

Package Code	Description	Package Rate (PHP)	Filing Period
Z025A1	Laparoscopic surgery for donor and open surgery for recipients	993,000	Within sixty (60) days after the date of discharge
Z025A2	Open surgery for both donor and recipients	865,000	

Table 1: Package Code, Description, Package Rate, and Filing Period for Living Organ Donor Transplantation with Induction Using Basiliximab

2. Living Organ Donor Transplantation using Rabbit anti-thymocyte globulin (rATG)

Package Code	Description	Package Rate (PHP)	Filing Period
Z025B1	Laparoscopic surgery for donor and open surgery for recipients	1,045,000	Within sixty (60) days after the date of discharge
Z025B2	Open surgery for both donor and recipients	918,000	

Table 2: Package Code, Description, Package Rate, and Filing Period for Living Organ Donor Transplantation with Induction using Rabbit anti-thymocyte globulin (rATG)

3. Deceased Organ Donor Transplantation using Basiliximab

Package Code	Description	Package Rate (PHP)	Filing Period
Z026A1	Kidney transplantation surgery with organ retrieval using machine perfusion	2,093,000	Within sixty (60) days after the date of discharge
Z0256A2	Kidney transplantation surgery with organ retrieval using cold storage	1,583,000	

Table 3: Package Code, Description, package Rate and Filing Period for Deceased Organ Donor with Induction using Basiliximab

4. Deceased Organ Donor Transplantation using Rabbit anti-thymocyte globulin (rATG)

Package Code	Description	Package Rate (PHP)	Filing Period
Z026B1	Kidney transplantation surgery with organ retrieval using machine perfusion	2,146,000	Within sixty (60) days after the date of discharge
Z026B2	Kidney transplantation surgery with organ retrieval using cold storage	1,636,000	

Table 4: Package Code, Description, package Rate and Filing Period for Deceased Organ Donor with Induction using Rabbit anti-thymocyte globulin (rATG)

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D. Kidney Transplantation Data Registry

1. The Kidney Transplantation (KT) Data Registry shall be developed and maintained by the reference health facility.

2. Once the KT Data Registry is operational, the contracted HFs shall register and update the information of all their patients in the KT Data Registry, whether enrolled under the Z Benefits or availed of the regular PhilHealth benefits.

3. The guidelines for the KT Data Registry shall be disseminated by PhilHealth.

E. Claims Filing

1. The contracted HFs shall deliver all the mandatory services.

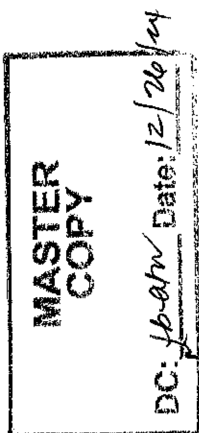
2. There shall be no direct filing of claims by the beneficiaries. All Z Benefits claims shall be filed by the contracted HF.

3. The contracted HF shall be responsible for the accuracy, adherence to guidelines, and efficient handling of all claims filed on behalf of patients. All required documents, forms, and attachments must be properly filled out before submitting claims within the prescribed period.

4. The contracted HFs shall properly indicate the OOP and/or copayment 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).

5. The contracted HFs shall follow existing guidelines of the SOA[10] requirement for claims submission under the Z Benefits.

6. Contracted HFs shall follow all relevant laws, such as RA No. 9994 or the "Expanded Senior Citizens Act of 2010" and RA No. 10754 or the "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 DOH-DSWD-PCSO-PHIC Joint Administrative Order No. 2020-0001 [Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019"].



With this, PhilHealth benefits and all mandatory discounts provided by law, such as senior citizen and PWD discounts, shall be deducted first from the patient's total hospital bill. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall be applied after PhilHealth deductions and complement the PhilHealth benefits packages.

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

7. The Z Satisfaction Questionnaire (Annex E) shall be accomplished by all patients enrolled in Z Benefits prior to final discharge disposition from the contracted HF. 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.

8. The contracted HFs shall submit properly accomplished forms and other documents for claims reimbursement based on the Checklist of Requirements for Reimbursement (Annex F).

9. Contracted HFs may file a motion for reconsideration (MR) or appeal any claims denied by PhilHealth in accordance with existing policies.

10. Existing rules on late filing shall apply. If the delay in the claims filing is due to natural calamities or other fortuitous events, the existing policy of the Corporation on the provisions of special privileges to those affected by fortuitous events shall apply.

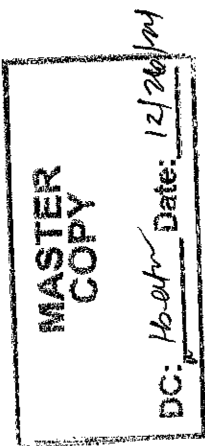
F. Claims Payment and Evaluation

1. PhilHealth shall reimburse covered services under the Z Benefits package following the predetermined package rates through case-based payment.

2. PhilHealth shall review 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 apply the "return to sender (RTS)" policy only for claims filed with incomplete documentary requirements. However, inconsistencies in data or information contained in the documents or non-provision of a mandatory service are grounds for automatic denial of the claim.

   Upon receipt of the notice of RTS, the contracted HFs shall comply with the deficiencies within the prescribed period based on the existing rules and regulations set by PhilHealth.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4. 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.

5. Any change of member/patient category after approval of the pre-authorization shall not affect the claims filed by the contracted HF.

6. Any amount declared in the SOA that is below or above the package rates shall not be interpreted as over or underpayment. PhilHealth can adjust payment rates in consideration of updates in standards of care and costing of standard health services validated with content experts.

7. PhilHealth shall process all claims submitted by the contracted HFs within thirty (30) working days upon receipt of claims applications, provided that the required documents and attachments are complied with.

8. 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. Late filing;
   c. Not registered in the KT registry or no KT registry matrix submitted
   d. Inconsistency of data and information contained in the claims application.

G. Monitoring

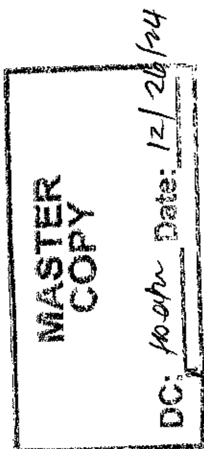
1. PhilHealth shall enforce current policies and guidelines on monitoring the performance of contracted HFs in implementing the Z Benefits Package for Kidney Transplantation and establish strict control mechanisms to ensure quality healthcare delivery and prevent adverse provider behaviors and non-compliance with existing rules.

2. PhilHealth also encourages content experts to review and conduct appropriate studies on healthcare providers' actual practices during the implementation of the Z Benefits Package for Kidney Transplantation, especially documenting adverse provider behaviors resulting in cost-push inflation, such as unwarranted increases in hospital charges.

3. PhilHealth beneficiaries are strongly encouraged to provide feedback or report any concerns about the implementation of the Z Benefits policy or their benefit availment experience by contacting the Corporate Action Center (CAC) through the hotline at (02) 8862-2588 or via email at actioncenter@philhealth.gov.ph.

4. Field monitoring activities shall be conducted for the service provision by contracted HFs. It shall follow the guidance, tools, and consent forms provided in PC No. 2021-0022.

5. 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.



H. Policy Review

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

I. Marketing and Promotion

PhilHealth shall conduct communication and social marketing activities to educate the 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 Social Marketing and Communication Plan of PhilHealth.

J. Annexes

Annex A: Pre-authorization Checklist and Request Form
Annex B: Supplementary Rules on Contracting Health Facilities
Annex C: List of Essential Health Services under Z Benefits Package for Kidney Transplantation
Annex D: Member Empowerment (ME) Form
Annex E: Z Satisfaction Questionnaire
Annex F: Checklist of Requirements for Reimbursement
Annex G: KT Data Registry
Annex H: Checklist of Essential Health Services
Annex I: Transmittal Form

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 and 10606 (National Health Insurance Act of 2013), RA No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, including the PhilHealth Rules on Administrative Cases (PROAC).

VII. TRANSITORY CLAUSE

A. Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to contracted HFs, ensure the availability of forms specified in this policy on the PhilHealth website, and implement the necessary enhancements in the claims system.

B. PhilHealth shall issue an Advisory once the ZBITS module is fully operational, including additional information and process. The module will generate a unique case number for every pre-authorization request submitted by the contracted HF. In the interim, the contracted HF shall assign a case number for tracking purposes, process the Pre-authorization Checklist and Request through the HCI portal, and attach the required documents, such as ME Form and MDT plan.

C. The contracted HF may resubmit a new pre-authorization checklist and request form to the PRO for patients with approved pre-authorization prior to the effectivity of this PhilHealth Circular.

D. Claims 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)."

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E. While the KT Registry is being developed, the contracted HFs shall assign a KT registration number to the patient and submit a KT Matrix (Annex. PhilHealth shall issue an Advisory or official notice to inform health facilities once the system is fully operational.

VIII. SEPARABILITY CLAUSE

If any part or provision of this PhilHealth Circular is declared unauthorized or invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. REPEALING CLAUSE

This PhilHealth Circular repeals specific provisions pertaining to the kidney transplantation under PhilHealth Circular No. 30, s-2012 titled "Case Type Z Benefit Package for Acute Lymphocytic (Lymphoblastic) Leukemia (ALL), Breast Cancer, Prostate Cancer and Kidney Transplant" and PC No. 2021-0022 "The Guiding Principles of the Z Benefits (Revision 1)."

All PhilHealth Circulars, issuances, rules, and regulations or parts 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 January 1, 2025 after 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.

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer

Date signed: 12/23/24

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Annex A: 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 teamphilhealth

Case No.________________

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER ☐ Same as above (Answer only if the patient is a dependent)	Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

(Place a ✓ on the appropriate answer)

History of Previous Kidney Transplantation	☐ Not Applicable
☐ Living Organ Donor: ☐ Related ☐ Non-Related	☐ Deceased Organ Donor
☐ Surgery (Date of Procedure (mm/dd/yyyy): ____________ ☐ Left ☐ Right	

PRE-AUTHORIZATION CHECKLIST
Kidney Transplantation Procedure

(Place a ✓ on the applicable procedure)

Type of Kidney Transplantation	Type of Immunosuppression	Type of Donor Nephrectomy
☐ Living Organ Donor ☐ Related ☐ Non-Related	☐ Basiliximab ☐ Rabbit anti-thymocyte globulin (rATG)	☐ Laparoscopic surgery for donor and open surgery for recipients ☐ Open surgery for both donor and recipients
☐ Deceased Organ Donor*		Type of Organ Preservation: ☐ Machine Perfusion ☐ Cold storage

*To be submitted within two (2) working days after completion of the surgery

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(Place a ✓ on the appropriate answer; otherwise, indicate a remark as applicable)

Selection Criteria	Remarks
1.1. On chronic dialysis because of chronic kidney disease (CKD) stage 5	☐ Yes ☐ NA
1.2. For preemptive kidney transplantation ☐ Diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear	☐ Yes ☐ NA

Selection Criteria	Remarks
GFR should be less than 20 mL/min /1.73m2. ☐ Non-diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 15 mL/min /1.73m2.	☐ Yes ☐ NA
2. Single organ transplant	☐ Yes
3. Negative T and B Cell Crossmatch	☐ Yes
4. History of kidney transplantation ☐ No (answer 4.1.a. and 4.1.b.) ☐ Yes (answer 4.2.a. and 4.2.b.)	
4.1.a. Historical Panel Reactive Antibody (PRA) Class 1 & 2 negative	☐ Yes ☐ NA
4.1.b. If Historical Panel Reactive Antibody (PRA) Class 1 and/or 2 is positive, must fulfill the following: i. Historical PRA less than or equal to 20% ii. No donor specific antibody (DSA) in the potential recipient	☐ Yes ☐ NA ☐ Yes ☐ Yes
4.2.a. PRA Screening <20% in both Class I and Class II 4.2.b. Absence of Donor Specific Antibodies (DSAs) by PRA Single Antigen Bead Assay	☐ Yes ☐ Yes
5. Absence of all of the following: a. Hemi-paralysis; b. Mental incapacity; and c. Substance abuse for at least 6 months prior to the start of transplant work-up.	☐ Yes
6. Absence of current severe illness (congestive heart failure class 3-4), liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension), chronic lung disease requiring oxygen, etc.	☐ Yes
7.1. History of cancer ☐ No ☐ Yes (answer 7.2)	
7.2. If with indolent and low-grade cancers after curative surgical/ablative treatment: ☐ Non-metastatic basal cell and squamous cell carcinoma of the skin removal ☐ Small renal cell carcinoma (< 3 cm) removal under radical nephrectomy; ☐ Prostate cancer (Gleason score ≤ 6) removal under radical prostatectomy ☐ Thyroid cancer (Follicular/Papillary <2 cm, of low-grade histology) removal under total/subtotal thyroidectomy ☐ Breast ductal carcinoma in situ removal under total mastectomy	☐ Yes ☐ NA

Selection Criteria	Remarks
Medical Clearance Date: ___________ I, _________________________________, oncologist, affiliated with ____, certifies that the patient's condition falls within the medical conditions specified under item 7.2 and can proceed to surgery. Oncologist: ______________________________ Printed name and signature PhilHealth Accreditation No.____________________	
8.1. Hepatitis C Negative Recipient	☐ Yes ☐ No
8.2. If Hepatitis C Positive Recipient ☐ No liver cirrhosis ☐ Completed the treatment for 12 weeks with Direct Acting Antivirals (DAA) before the kidney transplantation; ☐ For recipients with deceased organ donors: On at least 4 weeks of DAA treatment before allocation of deceased donor kidney (and treatment should be continued for a total of 12 weeks post KT) Medical Clearance Date: ___________ I, _________________________________, gastroenterologist, affiliated with ____, certifies that the patient's condition falls within the medical conditions specified under item 7.2 and can proceed to surgery. Gastroenterologist: ______________________________ Printed name and signature PhilHealth Accreditation No.____________________ Informed Consent Date: ___________ I, _________________________________, acknowledge and fully understand that I will be required to undergo antiviral prophylaxis for as long as it is medically prescribed. I have been informed that I will be personally responsible for any additional costs associated with this medication and other necessary interventions. Conforme by:______________________________ Printed name and signature ☐ Patient ☐ Parent ☐ Guardian	☐ Yes

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Selection Criteria	Remarks
9.1. HIV-Negative	☐ Yes ☐ No
9.2. HIV-Positive: HIV-1 RNA viral load below detectable levels while on antiretroviral therapy (<50 copies/mL) and CD4+ count should be >200 cells/mm3	☐ Yes ☐ NA
10. If the patient is HbsAg positive, all the following conditions must be met: a. absence of liver cirrhosis b. HBV- DNA <2,000 IU/ml Medical Clearance Date: ________ I, ____________________, gastroenterologist, affiliated with ____________________, certifies that the patient's condition falls within the medical conditions specified under item 10 and can proceed to surgery. Gastroenterologist: ____________________ Printed name and signature PhilHealth Accreditation No.____________ Informed Consent Date: ________ I, ____________________, acknowledge and fully understand that I will be required to undergo antiviral prophylaxis for as long as it is medically prescribed. I have been informed that I will be personally responsible for any additional costs associated with this medication and other necessary interventions. Conforme by:____________________ Printed name and signature ☐ Patient ☐ Parent ☐ Guardian	☐ Yes ☐ NA (If NA, proceed to Item No. 11.)
11. If the recipient is CMV IgG negative, any of the following should qualify: a. Donor is CMV IgG negative; OR b. Recipient is CMV IgG negative and donor is CMV IgG positive Informed Consent Date: ________ I, ____________________, acknowledge and fully understand that I will be required to undergo CMV prophylaxis for as long as it is medically prescribed. I have been informed that I will	☐ Yes ☐ NA ☐ Yes ☐ NA

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Selection Criteria	Remarks
be personally responsible for any additional costs associated with this medication and other necessary interventions. Conforme by:______________________________ Printed name and signature ☐ Patient ☐ Parent ☐ Guardian	

Certified correct by
Attending Nephrologist:

____
Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐–☐☐☐☐☐☐☐☐☐–☐

Certified correct by Attending Transplant Surgeon:

____
Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐–☐☐☐☐☐☐☐☐☐–☐

Conforme by:

____
Printed name and signature
☐ Patient ☐ Parent ☐ Guardian

Date Signed (mm/dd/yyyy):

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

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

PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for ______________________ in ______________________
(Patient's last, first, suffix, middle name) (Name of HF)

under the terms and conditions as agreed for availment of the Z Benefit Package.

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

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Nephrologist	(Printed name and signature) Attending Transplant Surgeon
PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐	PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

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

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) ______________________

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

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INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s) ______________________ (Printed name and signature) Head or authorized BAS representative		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐Approved ☐Disapproved			**Activity**	**Initial**	**Date**
Released to HF:			Received by BAS:		
The pre-authorization shall be valid for sixty (60) calendar days			☐ Approved ☐Disapproved		
			Released to HF:		

Annex B: Supplementary Rules on Contracting

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PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Supplementary Rules on Contracting Health Facilities

1. PhilHealth shall contract qualified accredited HFs to offer the services under the Z Benefits Package for Kidney Transplantation. These contracted HFs are required to provide the offered services of the benefits package to qualified patients.

2. The contract shall contain the terms and conditions agreed upon by PhilHealth and the accredited HFs. Co-payment, if applicable, shall not exceed the corresponding package rate.

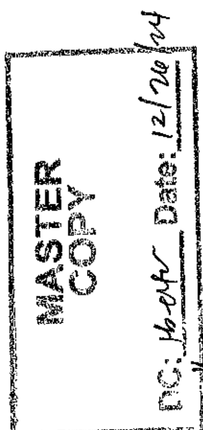
3. The accredited HFs shall submit co-payment proposals to PhilHealth. They shall identify the amenities or any additional or upgrade of services beyond the coverage of the benefits package. In cases of cost variance, the contracted HFs shall provide the necessary information to support the co-payment proposal or adjustment to the existing rates.

4. PhilHealth shall negotiate the proposed rates of the health services considered for inclusion in the co-payment arrangement submitted by the accredited HFs.

5. PhilHealth shall examine the co-payment proposal of the accredited HFs if these services are necessary for the patient's care but are not included in the identified essential health services.

6. Contracted HFs with an existing contract for the Z Benefits package for kidney transplantation shall update their co-payment proposal.

7. All other existing accrediting and contracting process shall apply



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

Annex C: List of Essential Health Services

1. Pre-transplant Workup

Descriptions	Essential Health Services
a. Pre-transplant evaluation for donor and recipient	1. Cardiology clearance for recipient 2. Cardiology clearance for donor (as needed) 3. Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates

2. Kidney Transplantation Procedures

Descriptions	Essential Health Services
a. Transplantation surgery with living or deceased donor a.1. Donor Nephrectomy (Living Organ Donor)	1. Laparoscopic surgery for donor and open surgery for recipients OR 2. Open surgery for both donor and recipients
a.2. Organ preservation (Deceased organ donor)	1. Used of machine perfusion OR 2. Cold storage

3. Medications

Descriptions	Essential Health Services
a. Immunosuppression therapy (as indicated)	1. Calcineurin inhibitor + mycophenolate + prednisone with or without induction a. cyclosporine + mycophenolate mofetil or mycophenolate sodium + prednisone OR b. tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone 2. Calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction a. Low-dose cyclosporine + sirolimus + prednisone OR b. Low-dose cyclosporine + everolimus + prednisone 3. Calcineurin inhibitor such as cyclosporine + azathioprine + prednisone with or without induction

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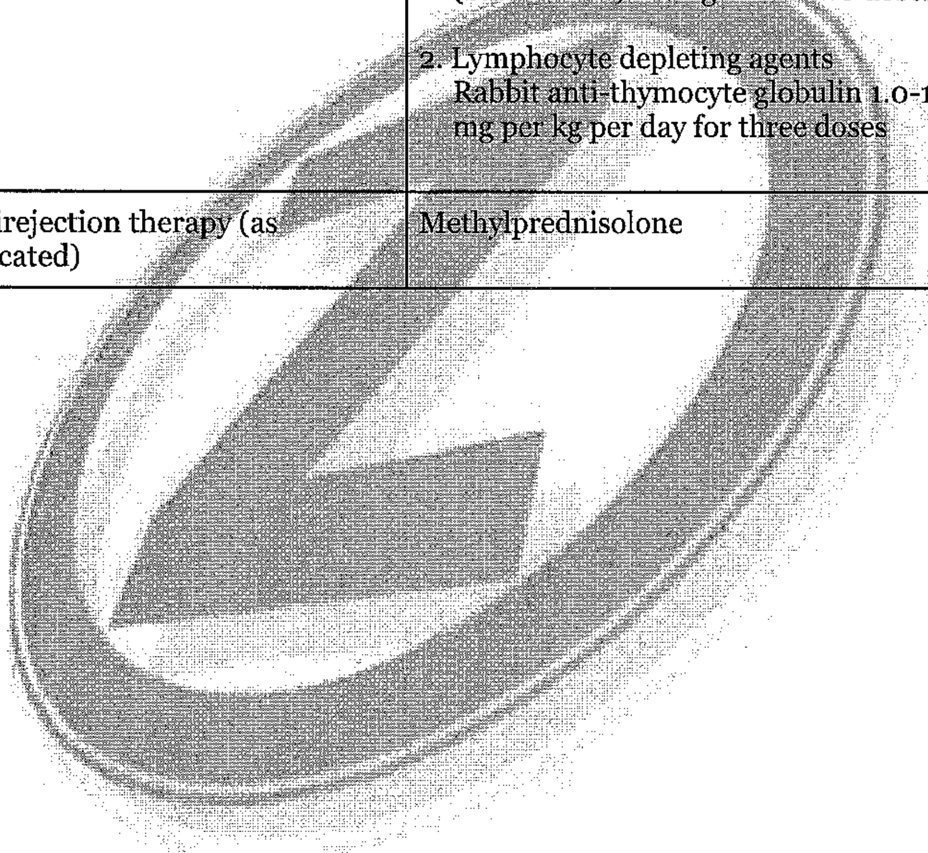
Descriptions	Essential Health Services
	4. Steroid-free for zero HLA-mismatch patient or induction using rabbit antithymocyte globulin
b. Induction therapy (as indicated)	1. Interleukin-2-receptor antibody (basiliximab) 20 mg IV for two doses 2. Lymphocyte depleting agents Rabbit anti-thymocyte globulin 1.0-1.5 mg per kg per day for three doses
c. Antirejection therapy (as indicated)	Methylprednisolone



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

Numero ng kaso: ________________
Case No.

MEMBER EMPOWERMENT FORM

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

Mga Panuto:
Instructions:

1. Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
   The health care provider shall explain and assist the patient in filling-up the ME form.
2. Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
   Legibly print all information provided.
3. Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka (✓) ang angkop na kahon.
   For items requiring a "yes" or "no" response, tick appropriately with a check mark (✓).
4. Gumamit ng karagdagang papel kung kinakailangan. Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
   Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
   The ME form shall be reproduced by the contracted health facility (HF) providing specialized care.
6. Dalawang kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente at sa ospital.
   Duplicate copies of the ME form shall be made available by the contracted HF—one for the patient and one as file copy of the contracted HF providing the specialized care.
7. **Para sa mga pasyenteng gagamit ng Z Benefit for Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, o Z Benefits para sa mga batang may kapansanan, isulat ang N/A sa tala B2, B3 at D6. Para naman sa Peritoneal Dialysis (PD) First Z Benefits, isulat ang N/A para sa tala B2 at B3.**
   For patients availing of the Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH) for fitting of the external lower limb prosthesis, or Z Benefits for children with disabilities, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

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

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

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

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

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

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

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

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

Kategorya bilang Miyembro:
Membership Category:

Direct contributor
Direct contributor

☐ Empleado ng pribadong sector *Employed private*
☐ Empleado ng gobyerno *Employed government*
☐ May sariling pinagkakakitaan *Self-earning*
- ☐ Indibidwal *Individual*
- ☐ Sole proprietor *Sole proprietor*
- ☐ Group enrollment scheme *Group enrollment scheme*

☐ Kasambahay / *Household Help*
☐ Tagamaneho ng Pamilya/ *Family driver*
☐ Filipinong Manggagawa sa ibang bansa *Migrant Worker/OFW*
- ☐ Land-based *Land-based*
- ☐ Sea-based *Sea-based*

☐ Habambuhay na kaanib/ *Lifetime Member*
☐ Filipino na may dalawang pagkamamamayan/Nakatira sa ibang bansa *Filipino with Dual Citizenship/Living abroad*
☐ Foreign national/*Foreign national*

Indirect contributor
Indirect contributor

☐ Listahanan *Listahanan*
☐ 4Ps/MCCT *4Ps /MCCT*
☐ Nakatatandang mamamayan *Senior Citizen* (RA 10645)
☐ PAMANA *PAMANA*
☐ KIA/KIPO *KIA/KIPO*
☐ Bangsamoro/Normalization

☐ Inisponsuran ng LGU *LGU-sponsored*
☐ Inisponsuran ng NGA NGA-*sponsored*
☐ Inisponsuran ng pribadong sector *Private-sponsored*
☐ Taong may kapansanan *Person with disability*

Iba pa
Others
☐ Point of Service (POS) Financially Incapable

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

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

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

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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* ______________________________ * 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.		

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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.*		

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

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

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

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

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

Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng Z benefits ng PhilHealth. *I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.*		
Buong pangalan at lagda ng pasyente* *Printed name and signature of patient** * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon) *Relationship of representative to patient (tick appropriate box)* ☐ asawa *spouse* ☐ magulang *parent* ☐ anak *child* ☐ kapatid *next of kin* ☐tagapag-alaga *guardian* ☐ walang kasama *no companion*		

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Annex E: Z Satisfaction Questionnaire

PhilHealth

Benefits

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health facility or you may contact PhilHealth call center at 8441-7442. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:
- ☐ Acute lymphoblastic leukemia
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Kidney transplantation
- ☐ Cervical cancer
- ☐ Coronary artery bypass surgery
- ☐ Surgery for Tetralogy of Fallot
- ☐ Surgery for ventricular septal defect
- ☐ ZMORPH/Expanded ZMORPH
- ☐ Post kidney transplantation services
- ☐ Orthopedic implants
- ☐ PD First Z benefits
- ☐ Colorectal cancer
- ☐ Prevention of preterm delivery
- ☐ Preterm and small baby
- ☐ Children with developmental disability
- ☐ Children with mobility impairment
- ☐ Children with visual disability
- ☐ Children with hearing impairment

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

3. Sex of respondent
- ☐ male
- ☐ female

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

4. How would you rate the services received from the health facility (HF) in terms of availability of medicines or supplies needed for the treatment of your condition?
- ☐ adequate

- inadequate
- don't know

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

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

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

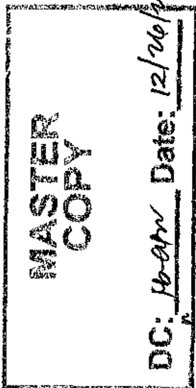
8. Overall patient satisfaction (PS mark) is:
- excellent
- satisfactory
- unsatisfactory
- don't know

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

____

____

____



Thank you. Your feedback is important to us!

____

Signature of Patient/ Parent/ Guardian

Date accomplished: ________________

Annex F: Checklist of Requirements for Reimbursement

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. ____________________

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number	☐☐-☐☐☐☐☐☐☐☐☐-☐
B. MEMBER ☐ *Same as patient (Answer only if the patient is a dependent)*	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number	☐☐-☐☐☐☐☐☐☐☐☐-☐

Checklist of Requirements for Reimbursement
Kidney Transplantation (Living or Deceased Organ Donor)

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

REQUIREMENTS	Status
1. Photocopy of completely accomplished pre-authorization checklist and request form (Annex A)	
2. Photocopy of the MDT Plan	
3. Photocopy of properly accomplished Member Empowerment (ME) Form (Annex D)	
4. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
5. Properly Accomplished PhilHealth Claim Form 2 (CF2)	
6. Properly accomplished kidney transplant registry matrix (Annex D)	
7. Completed Z Satisfaction Questionnaire (Annex E)	
8. Checklist of Requirements for Reimbursement (Annex F)	
9. Checklist of Essential Health Services (Annex H) with the attached documents of pre-transplant Evaluation Form for KT Recipient and Donor	
10. Transmittal Form (Annex I)	
11. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent	
12. Photocopy of accomplished surgical operative report of recipient and donor or similar documents	
13. Photocopy of Anesthesia Record or similar documents	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

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

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Annex G: Kidney Transplant Data Registry

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Form No.4 Series Feb 2008

CASE NO. ______
Encode 1 ______ Date ______
Review ______ Date ______
Revision requested ☐ Yes ☐ No
Rev. complete ______ Date ______
Encode 2 ______ Date ______

KIDNEY TRANSPLANT REGISTRY

Philippine Renal Disease Registry
DOH/NKTI Renal Disease Control Program - Philippine Society of Nephrology

HOSPITAL/TRANSPLANT CENTER ______
DATE COMPLETED (mm/dd/yyyy) ______
COMPLETED BY ______

ENTRY FORM FOR A KIDNEY TRANSPLANT PATIENT

NOTE: PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY

PHILHEALTH NUMBER ☐☐-☐☐☐☐☐☐☐☐☐-☐ ☐ Pay ☐ Service

LAST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
FIRST NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
MIDDLE NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
DATE OF BIRTH ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y) SEX ☐ Male ☐ Female
CIVIL STATUS ☐ Single ☐ Married ☐ Widow ☐ Separated

ETHNICITY (See guide at the back)
- ☐ White
- ☐ Black
- ☐ Filipino
- ☐ Asian (Non-Filipino)
- ☐ Mixed Filipino
- ☐ Pacific Islander
- ☐ Mid Eastern/Arabian
- ☐ Indian Sub-continent
- ☐ Mixed Non-Filipino
- ☐ Others ______
- ☐ Unknown

PERMANENT ADDRESS ______ TEL. NO. ______
PRESENT ADDRESS ______ TEL. NO. ______
NAME OF RELATIVE NOT LIVING WITH PATIENT ______ TEL. NO. ______
ATTENDING PHYSICIAN: Nephrologist ______ Transplant Surgeon ______

1. **PRIMARY RENAL DISEASE** (CAUSE OF END STAGE RENAL DISEASE)
   Do not write ESRD, CRF, CKD, ARF
   - ☐ GN Biopsy proven. Specify ......
   - ☐ GN Clinical (RBC cast OR proteinuria > 2 grams/day)
   - ☐ CPN Biopsy proven OR with radiologic evidence of reflux nephropathy
   - ☐ CPN Clinical (History of UTI or urolithiasis)
   - ☐ Hypertensive Nephrosclerosis, biopsy proven
   - ☐ Hypertensive Nephrosclerosis clinical (Hypertension precedes ESRD by at least 5 years)
   - ☐ Autosomal Dominant Polycystic Kidney disease
   - ☐ Diabetic Nephropathy
   - ☐ Unknown
   - ☐ Others, Specify ......
2. **CO-EXISTING DISEASE** (may check more than one)
   Do not write Anemia, Uremia
   - ☐ None
   - ☐ Diabetes Mellitus
   - ☐ Hypertension
   - ☐ PTB, active by Chest X-Ray
   - ☐ COPD
   - ☐ Ischemic Heart Disease, (not in CHF) defined as:
     - Previous Myocardial Infarction
     - Angina pectoris, unstable angina
     - Medications (nitrates, etc.)
   - ☐ Congestive Heart Failure (any etiology)
   - ☐ Stroke (Cerebrovascular Accident)
   - ☐ Collagen Disease. Specify ......
   - ☐ Malignancy. Specify ......
   - ☐ Gout
   - ☐ Others, Specify ......
3. **TYPE OF CHRONIC DIALYSIS PRIOR TO THIS TRANSPLANT**
   ☐ Hemodialysis ☐ Peritoneal dialysis ☐ Never on dialysis
4. **LENGTH OF TIME ON DIALYSIS PRIOR TO THIS TRANSPLANT** (month) ......
5. **NUMBER OF PREVIOUS KIDNEY GRAFTS** ......
6. **ORGANS TRANSPLANTED ASIDE FROM KIDNEY** ......
7. **THIS TRANSPLANT DATE** ☐☐ ☐☐ ☐☐☐☐ (m m d d y y y y)
8. **COLD ISCHEMIA TIME** (minutes) ......
9. **DONOR SOURCE** ☐ Deceased ☐ Living
10. **IF DECEASED, STATE CAUSE OF DEATH** ......
11. **FOR LIVE DONOR, STATE RELATIONSHIP OF DONOR TO RECIPIENT** ......
12. **NAME OF DONOR** (Last Name, First Name, Middle Name) ......
13. **LIVING NON-RELATED DONOR CLASSIFICATION**
    - ☐ Directed Donor
      - ☐ Emotionally related donor
      - ☐ Socially affiliated donor
    - ☐ Non-Directed
14. **DATA & HLA TYPING**

DATA & HLA TYPING	RECIPIENT		DONOR	
AGE (yrs)				
SEX (M/F)				
BLOOD TYPE				
PTB Status (+/-/ND)				
CMV Status (+/-/ND)				
HBsAg Status (+/-/ND)				
Anti-HCV Status (+/-/ND)				
HIV Status (+/-/ND)				
HLA Typing A				
B				
DR				

FOR RECIPIENT ONLY (Write ND if not done)	
PRA - CLASS I (%)	
PRA - CLASS II (%)	

15. **ANTI-INFECTIVE PROPHYLAXIS POST KT**
    - ☐ None
    - ☐ INH
    - ☐ Nystatin
    - ☐ Others, Specify ......
    - ☐ Co-Trimoxazole
    - ☐ Acyclovir
    - ☐ Valacyclovir
    - ☐ Gancyclovir ☐ PO ☐ IV
    - ☐ Valgenciclovir
16. **INDUCTION/DESENSITIZATION IMMUNOSUPPRESION**
    - ☐ None
    - ☐ DST
    - ☐ OKT3
    - ☐ ATG/ALG
    - ☐ IVIg
    - ☐ Others, Specify ......
    - ☐ Rituximab (Mabthera)
    - ☐ Alemtuzumab (Campath)
    - ☐ Basiliximab (Simulect)
    - ☐ Daclizumab (Zenapax)
    - ☐ Plasmapheresis
17. **INITIAL MAINTENANCE IMMUNOSUPPRESSION**
    (Check all drugs given)
    - ☐ Cyclosporin A
    - ☐ Azathioprine
    - ☐ Prednisone
    - ☐ Rapamycin
    - ☐ Others, Specify ......
    - ☐ Mycophenolate mofetil (Cellcept)
    - ☐ Mycophenolate sodium (Myfortic)
    - ☐ Tacrolimus (Prograf)
    - ☐ Everolimus (Certican)

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GUIDE TO CLASSIFICATION OF ETHNICITY

White - A person having origins in any of the original white people of Europe.

Black - A person having origins in any of the black racial groups of Africa.

Filipino - A person having origins in the Philippines. Check this for all pure Filipinos & Filipinos with foreign blood <25%.

Asian (Non Filipino) - A person having origins in any of the original peoples of the Far East and Southeast Asia other than the Philippines. Check this if both parents Asian but not Filipino.

Pacific Islander - A person having origins in any of the following peoples of the Pacific Islands. Example of these areas include the Samoa and Hawaiian Islands.

Mid-Eastern/Arabian - A person having origins in any of the peoples of the Middle East and Northern Africa. Examples of these areas include Egypt, Israel, Iran, Iraq, Saudi Arabia, Jordan, and Kuwait.

Indian Sub-Continent - A person having origins in any of the peoples of the Indian Sub-continent. Examples of these areas include India, Pakistan, Sri Lanka, and Bangladesh.

Mixed Filipino - Check this for Filipinos with foreign blood ≥ 25%.

Mixed Non-Filipino - Check this if neither parent is Filipino.

Other, specify - A person not having origins in any of the above categories. Write race(s) in space provided.

Unknown - Check this box if race is unknown.

CLASSIFICATION OF LIVING NON-RELATED DONORS

DIRECTED DONOR :

a. Emotionally related donor - a person who donates an organ to a non-blood relative but is emotionally related to the recipient example: Spouse, in-law, friend, adoptive parent or child.

b. Socially affiliated donor - a person who donates an organ to a non-blood relative recipient but has pre-existing non-coercive relationship such as in employer-employee example: driver, janitor, farm worker, house helper, churchmate, co-organization, co-fraternity.

NON-DIRECTED DONOR : a person who donates an organ to a non-blood relative recipient and does not belong to any of the above examples

17. EPISODE OF GRAFT DYSFUNCTION FROM THIS TRANSPLANT ADMISSION TO TIME OF DISCHARGE ☐ YES, Go to no 18. ☐ NO (END OF FORM)

18. CHECK THE NATURE OF GRAFT DYSFUNCTION FROM THIS TRANSPLANT ADMISSION TO TIME OF DISCHARGE.

ATN, by biopsy or nuclear scan	☐ Yes	☐ No
ATN, clinical (episode of renal graft ischemia; Ex. hypotension, cold ischema > 24 hrs.)	☐ Yes	☐ No
Rejection, by biopsy	☐ Yes	☐ No
Rejection, clinical (decrease in creatinine after anti-rejection treatment)	☐ Yes	☐ No
Immunosuppression toxicity.	☐ Yes	☐ No
Technical problem (Ex. Anastomosis leak)	☐ Yes	☐ No
Others, Specify	☐ Yes	☐ No

19. IF REJECTION EPISODE OCCURRED, COMPLETE THE FOLLOWING TABLE:

Instructions: **Indicate under TREATMENT**
- S - Steroids
- ATG - ATG
- OKT3 - OKT3
- O - Others, please specify
- N - None, state reason

Indicate under RESPONSE
- CR - Complete response (Return to baseline creatinine)
- PR - Partial response (Stable reduction in creatinine achieved but NOT back to baseline)
- NR - No response (Creatinine continues to rise or dialysis-dependent)

DATE (mm/yyyy)	TREATMENT	RESPONSE

Use this space for explanation

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PhilHealthOfficial teamphilhealth

Case No. ____________________

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number	☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
B. MEMBER ☐ *Same as patient (Answer only if the patient is a dependent)*	1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number	☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF MANDATORY AND OTHER SERVICES
Kidney Transplantation

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

Essential Health Services	
☐ Cardiology clearance for recipient	☐ Cardiology clearance for donor (as needed)
☐ Pre-transplant evaluation/labs (Phases 1, 2, 3 and 4) for donor and recipient candidates	☐ Hemodialysis or peritoneal dialysis during admission for transplantation (as indicated)
☐ Transplantation surgery with living or deceased donor	
☐ Immunosuppressant induction therapy, unless identical twin or zero HLA-antigen mismatch	
☐ Immunologic risk- Negative tissue crossmatch between donor and recipient, single organ transplant, PRA class 1 and 2 negative or PRA<20%; no donor specific antibody	

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Essential Health Services	
Immunosuppression options: (Tick any one of the following) ☐ Calcineurin inhibitor + mycophenolate + prednisone with or without induction a. cyclosporine + mycophenolate mofetil or mycophenolate sodium + prednisone OR b. tacrolimus + mycophenolate mofetil or mycophenolate sodium + prednisone ☐ Calcineurin inhibitor + mTOR inhibitor + prednisone with or without induction a. Low-dose cyclosporine + sirolimus + prednisone OR b. Low-dose cyclosporine + everolimus + prednisone ☐ Calcineurin inhibitor such as cyclosporine + azathioprine + prednisone with or without induction ☐ Steroid-free for zero HLA-mismatch patient or induction using rabbit antithymocyte globulin	
Induction therapies (choose any of the following): ☐ Interleukin-2-receptor antibody (basiliximab) 20 mg IV for two doses ☐ Lymphocyte depleting agents Rabbit anti-thymocyte globulin 1.0-1.5 mg per kg per day for three doses	
For Living Donor Kidney Transplants only Type of Donor Nephrectomy: ☐ Laparoscopic ☐ Open	
For Deceased Donor Kidney Transplant only Type of Organ Preservation: ☐ Automated Machine Perfusion ☐ Cold Storage	
	Anti-rejection therapy (as indicated) ☐ Methylprednisolone 500 mg IV per day for three days
	☐ Graft renal biopsy (as indicated)

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

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PRE-TRANSPLANT EVALUATION FORM FOR KIDNEY TRANSPLANT RECIPIENT
Attachment to the Claim*

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

Name (Last, First, MI) ______________________________

☐ Without co-payment ☐ With co-payment

Age _____ Sex ☐ Male ☐ Female Civil Status: ☐ Single ☐ Married ☐ Widow ☐ Separated

Race ______________________________ Hospital No. ______________________

Permanent Address ____

______________________________ Tel. No. ______________________

Present Address ____

______________________________ Tel. No. ______________________

Attending Nephrologist______________ Transplant Surgeon ______________

Name of Donor (Last, First, MI) ______________________________

PhilHealth ID No. ☐☐-☐☐☐☐☐☐☐☐☐-☐

Primary Renal Disease ______________________________ ☐ Clinical ☐ Biopsy Proven

Duration of Dialysis __________ Mode of Dialysis ☐ None ☐ HD ☐ PD, specify__________

KT History ☐ 1st ☐ 2nd ☐ Specify, ______________ ☐ Other organ grafted __________

Anemia management: ☐ BT, ______________ # units Date of last BT __________

☐ EPO, Dose______________

Past Medical/Social History:

☐ HPN ☐ DM ☐ Asthma ☐ Renal Stone ☐ COPD ☐ # of Previous Pregnancies

☐ CAD ☐ Stroke ☐ PVD ☐ Liver Disease ☐ Lupus

☐ Splenectomy ☐ Others, specify ______________________

☐ Previous Surgeries ______________________ ☐ Allergies ______________

☐ Smoking (Pack years) ______________________ ☐ Alcohol Intake ______________

Family history ☐ HPN ☐ DM ☐ CAD ☐ Others, specify ______________________

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

Hematology (___/___/___)

*WBC______ * Hgb______ *Hct ______ *Platelet ______ *Bleeding Time ______ *PT _______ *PTT ______

Blood Chemistries (___/___/___)

*Creatinine _____ *BUN_______ *FBS _______ * Cholesterol _______ *Trig _______

*Uric Acid _______ SGOT ______ *SGPT ______ *Albumin ______ *Ca _______

*P __________ *K __________ *Na ________ Intact PTH _______

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

*Sp. Gr. ______ pH ________ Protein______ Sugar____ Blood______ WBC______ RBC______

*Urine culture and sensitivity (___/___/___)______________________________

24-hour urine (___/___/___) ECC______________ TP______________________

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

*Stool Examination with occult blood test (___/___/___)

*Throat swab culture and sensitivity (___/___/___)

*Chest X-ray (___/___/___)

*Whole Abdomen US (___/___/___)

*ECG (___/___/___)

*2D Echo (___/___/___) EF______%

Sputum c/s (___/___/___)

Chest CT scan (___/___/___)

EGD (___/___/___)

Colonoscopy (___/___/___)

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

Carotid doppler, when indicated (___/___/___)

Dobutamine Stress Echo, when indicated (___/___/___)

Cardiac scintigraphy (___/___/___)

Serology: (___/___/___)

*HBs Ag______ *Anti-HBc______ *Anti-HBs______ HBV-DNA______ *Anti-HCV______ HCV-RNA______
*HIV/HACT______ *VDRL______ *CMV IgG titer______ *EBV______ *PSA (for males > 50 yo)______

Immunology: *PRA Screen (___/___/___) Class I____% Class II____%
*PRA Specific if PRA Screen Positive, PRA Specific/PRA Single Antigen Bead (___/___/___)
*Tissue Crossmatch (___/___/___)

*Blood Type ______ *Tissue Typing ______A______, ______B______, ______DR______, ______ No. of HLA Mismatch ______

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

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

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

*Cardiovascular ______________ Pulmonary ______________

Infectious ______________ Urology/Gynecology ______________

Dental ______________ Others ______________

* Essential Health Services

Certified correct by Attending Nephrologist or Transplant Surgeon:

____
Printed name and signature

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

Date signed:

____

MASTER COPY
DC: [handwritten] Date: 12/[handwritten]

PRE-TRANSPLANT EVALUATION FORM FOR KIDNEY TRANSPLANT DONOR
Attachment to the Claim*

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

Name (Last, First, Middle)____

☐ Without co-payment ☐ With co-payment

Age ________ Sex ☐ Male ☐ Female Civil Status: ☐ Single ☐ Married ☐ Widow ☐ Separated

Race ________________________________ Hospital No. ______________________

Permanent Address ____

____Tel. No. ______________

Present Address ____

____Tel. No. ______________

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

____

____ Tel. No. ____________

Nephrologist _________________________ Transplant Surgeon ______________________

Urologist ____

PhilHealth ID No. ☐☐-☐☐☐☐☐☐☐☐☐-☐

PRE-KIDNEY DONATION DATA

Name of Recipient (Last, First, MI) ______________________________________

Specific relationship to the recipient

☐ Living Related Donor

☐ parent ☐ sibling ☐ child ☐ first cousin ☐ nephew/niece ☐ aunt/uncle

☐ Living Non-related Donor

State relationship ____

Past Medical and Social History

☐ No Disease ☐ HPN ☐ DM ☐ Asthma ☐ Renal Stone

☐ Previous Surgeries ______________________

☐ Allergies ______________________________

☐ Smoking______________________________ pack- years

☐ Alcohol Intake ________________________ drinks/per day x _________ years

☐ Maintenance Medications and dose___________________________________

☐ Others, specify ________________________

Family history

☐ HPN ☐ DM ☐ Renal Disease, specify ____________________

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

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DC: [illegible] Date: 12/20/[illegible]

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

Hematology (___/_____/_____)

*WBC______ *Hgb______ *Hct______ *Platelet______ *PT______ *PTT______

Blood Chemistries (____/____/____)

*Crea _______ BUN________ *FBS _______ *Chole _______ *Trig ________

*SGPT ______ *K _________ *Na __________ Ca _________ P _________ *Uric Acid ______

Others ____

Urine Examination:

* (___/___/___) Sp.Gr.______ pH_____ Protein____ Blood____ Sugar____ WBC_____ RBC______

* (___/___/___) 24-hour urine TP ______________ or Urine Protein Creatinine ratio __________

* (___/___/___) Urine culture and sensitivity ______________________________

Serology:

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

Other tests:

Stool Exam with Occult Blood: (___/___/___) ______________________________

* Chest X-ray (___/___/___) ______________________________

* Whole Abdominal US (___/___/___) ______________________________

____

* ECG (___/___/___) ______________________________

____

* Nuclear GFR (___/___/___) __________ml/min Normalized GFR __________ml/min

Right_______ml/min _______%, Left_________ml/min ________%

* CT Renal Angiography (___/___/___) ______________________________

____

* Blood Type _____ *Tissue Typing _____ A______, ______B______, ______DR________, ______

No. of HLA Mismatch ______________________________

CLEARANCES (Indicate the dates and physicians)

Cardiovascular (___/___/___) ______________________________

Pulmonary (___/___/___) ______________________________

Infectious (___/___/___) ______________________________

Urology (___/___/___) ______________________________

Gynecologic (___/___/___) ______________________________

Others (___/___/___) ______________________________

☐ * Pre-transplant Orientation (___/___/___) ☐ * Ethics Committee, if LNRD (___/___/___)

* Essential Health Services

Certified correct by Attending Nephrologist or Transplant Surgeon:

____

Printed name and signature

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

Date signed:

____

MASTER COPY
DC: Ho-am Date: 12/26/24

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial 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, indicate the code based on the services provided. Example: Z0024A1
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

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

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

MASTER COPY
Date: 12/26/24