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

PHILHEALTH CIRCULAR
No. 2024-0036

TO : **ALL ACCREDITED HEALTH FACILITIES FOR THE Z BENEFITS FOR PERITONEAL DIALYSIS, AND ALL OTHERS CONCERNED**

SUBJECT : **Z Benefits Package for Peritoneal Dialysis (PD)**

I. RATIONALE

Chronic kidney disease (CKD) is a global public health concern, with a 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 the 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.[3]

Republic Act (RA) No. 7875, as amended by RA Nos. 9241 and 10606, mandates PhilHealth to provide responsive benefit packages and improve its benefits package to meet the needs of its members, paving the way for the development of the Z Benefits Package for End-stage Renal Disease Requiring Peritoneal Dialysis (PD) or the PD First Z Benefits in 2014 covering PD bags solutions and transfer set. With the enactment of RA 11223 or the Universal Health Care Act, PhilHealth shall ensure that all Filipinos are guaranteed equitable access to quality and affordable healthcare goods and services, and are protected against financial risk. This benefits package has to be updated to align with the current standards, practice and cost of care.

Thus, through Board Resolution No. 2962 s. 2024, the PhilHealth Board of Directors approved the coverage of the Z Benefits Package for Peritoneal Dialysis for adult and pediatric patients to provide responsive benefits packages and strengthen PD as the initial line of treatment for Filipinos with CKD5 requiring renal replacement therapy.

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[1] Kovesdy CP. (2022) Epidemiology of chronic kidney disease: an update. Kidney Int Suppl (2011). 2022;12(1):7-11. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9073222/

[2] Suriyong P, Ruengorn C, Shayakul C, Anantachoti P, Kanjanarat P. (2022) Prevalence of chronic kidney disease stages 3-5 in low- and middle income countries in Asia: a systematic review and meta-analysis. PLoS One. 2022;17(2): e0264393: https://doi.org/10.1371/journal.pone.0264393

[3] https://nkti.gov.ph/index.php/patients-and-visitors/kideny-health-plus

II. OBJECTIVES

This PhilHealth Circular aims to expand the coverage for peritoneal dialysis and ensure equitable access to quality healthcare services and financial risk protection.

III. SCOPE

This PhilHealth Circular shall apply to all accredited PD Z providers and all others involved in the implementation of the Z Benefits Package for PD for patients diagnosed with chronic kidney disease (CKD) Stage 5.

IV. DEFINITION OF TERMS

A. **Automated Peritoneal Dialysis (APD)**[4] – refers to a type of PD modality which is done with the use of a cycler machine. The usual duration of the APD is eight to ten hours, commonly done at night. A day dwell may be added to night APD to increase peritoneal clearance.

B. **Accredited PD Z Provider** – refers to a PhilHealth–accredited health facility that enters into a contract with PhilHealth to provide the provision of essential health services for enrolled PD Z Benefits patients.

C. **Case-based Provider Payment Mechanism** – refers to a provider payment system in which a facility is reimbursed for each discharged patient at a predetermined rate based on the type of case or for groups of cases with similar clinical profiles and resource requirements.

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. **Continuous Ambulatory Peritoneal Dialysis (CAPD)**[5] – refers to a type of PD modality that provides continuous therapy at a steady physiologic state. CAPD is done manually by a patient or caregiver multiple times daily. Each PD exchange lasts for 30 to 40 minutes. A typical CAPD prescription consists of two to three daytime exchanges and two nighttime dwellings.

F. **Copayment** – refers to a predetermined amount agreed upon by the accredited health facility (HF) and PhilHealth that is chargeable to patients to cover the share for amenities, choice of physician, or any additional or upgraded services during the episode of care before service access to manage moral hazards and adverse incentives.[6] Copayment is an example

[4] Peritoneal Dialysis Manual (2023). National Kidney and Transplant Institute
[5] Ibid.
[6] PC No. 2021-0022. The Guiding Principles of the Z Benefits *(Revision 1)*

of an out-of-pocket payment or cost-sharing mechanism intended to share the cost of healthcare between the insured and the insurer.[7]

G. **Eligibility Criteria** - refers to a set of requirements to determine whether an individual is qualified to avail of the benefits package.

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 (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. **Lost to Follow-up** – refers to a patient who has not come back as advised for the next consultation or visit, whichever is applicable. In the context of the PD Z Benefits, this refers to a situation where, after 60 days of the scheduled visit or follow-up, the patient cannot be located nor found in their home address after the health facility exerted all possible means to locate the patient.

J. **Member Empowerment (ME) Form** – refers to a document showing that the patient is fully informed of their Z Benefit package, treatment options, treatment schedule and follow-up visits, roles and responsibilities. A. 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**[8] – 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. **Peritoneal Dialysis (PD)**[9] – refers to a modality of renal replacement therapy that makes use of the peritoneal membrane in achieving solute clearance and ultrafiltration. PD can be performed either manually as in CAPD or using mechanical devices as in APD.

M. **Peritoneal Dialysis (PD) Passport**[10] - refers to the record of patients availing of the PD Z Benefits Package that serves as source of data on the number of PD exchanges per day prescribed to the patient, date of dispensing of PD bags, inclusive dates, and date of next claims, among

[7] Ibid.
[8] Ibid.
[9] Peritoneal Dialysis Manual (2023). National Kidney and Transplant Institute
[10] Ibid.

others. This shall serve as a source of data during patient transfer, claims payment, and monitoring.

N. PhilHealth Dialysis Database (PDD)[11] – refers to a system that collects data on members and dependents diagnosed with CKD5 (previously known as ESRD) who are prescribed hemodialysis (HD), PD, or kidney transplantation (KT).

O. Renal Replacement Therapy[12] – 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. Telemedicine[13] – refers to the delivery of healthcare services, where distance is a critical factor, by all healthcare professionals using information and communication technologies to exchange valid information for diagnosis, treatment, and prevention of disease, continuing education of healthcare providers, all in the interest of advancing the health of individuals and their communities.

V. POLICY STATEMENTS

A. Benefits Availment

1. All patients diagnosed with CKD5 shall be registered in the PDD in accordance with the existing guidelines.

2. CKD5 patients who will require PD catheter insertion and initiation may avail of the applicable benefits package (i.e., Z024A) only in accredited PD Z providers. These patients are not yet required to be enrolled in the PD Z Benefits packages.

3. The patient shall be enrolled in the PD Z Benefits package as soon as they have a permanent peritoneal dialysis catheter and fulfills the eligibility criteria (Annex A: Checklist of Eligibility Criteria).

4. Upon enrollment to this benefits package, the patient shall receive the services of PD solutions and subsequent treatment or services listed in the essential health services (Annex B: List of Essential Health Services for Peritoneal Dialysis Z Benefits).

5. PhilHealth beneficiaries to be enrolled in the PD Z Benefits shall comply with the existing membership eligibility guidelines.

[11] PhilHealth Circular No. 2026-007
[12] Ibid.
[13] Ibid.

6. Patient enrollment under this benefits package is a one-time process in which individuals are registered and their eligibility is determined by the accredited PD Z provider. Once enrolled, they may continuously avail themselves of the benefits as long as they remain eligible, meet the required criteria, or not declared lost to follow up.

7. The registry number generated by the PDD, along with its date, shall be indicated in the Checklist of the Eligibility Criteria as proof of registration, subject to verification of the PhilHealth Regional Office (PRO).

8. The designated liaison of the accredited PD Z provider shall submit the properly accomplished photocopy of the Eligibility Criteria Checklist and a photocopy of the properly accomplished ME Form (Annex C) to the Local Health Insurance Office (LHIO) or the office of the Head of the PhilHealth BAS with jurisdiction over the accredited PD Z providers. During the initial availment of the benefits package, all photocopies of documents shall be included in the submission of the requirements for claims reimbursement. The original copies of these documents must be attached to the patient's record and readily accessible for verification during monitoring and evaluation of the benefits package.

   Note: Case rates for PD shall be limited to acute kidney injury with indications for renal replacement therapy (e.g., leptospirosis).

9. The ME Form shall be accomplished together by the attending health care professional/ s in the accredited PD Z provider and the patient for enrolment in the Z benefits for PD. The accredited PD Z provider shall fully explain the contents and significance of the ME Form to the patient prior to the enrollment to the PD Z package in the language that the patient understands.

10. The 45-day annual benefit limit shall not be applied in this Z Benefits package.

11. The accredited PD Z provider shall prescribe and dispense PD solution to the patient according to the tranche schedule in this benefits package.

12. If the next tranche schedule of prescription and/or dispensing of PD bags falls on a weekend or a holiday, the accredited PD Z providers may prescribe and/or dispense the PD bags at an earlier working day to ensure continuous treatment of the patient. This shall not be considered as overlapping claims and must be processed accordingly based on the existing guidelines set by the Corporation.

13. The accredited PD Z provider shall not charge copayment for essential health services listed in Annex B.

14. The accredited PD Z provider may charge copayment or out-of-pocket (OOP) payment for services that are not included in the list of essential health services (Annex B) and amenities that are provided to the patient

but are not covered by the Z Benefits package. This copayment is mutually agreed upon by the patient and contracted HFs during the discussion of the ME form for services beyond the scope of essential health services.

15. 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.

16. Hospital confinements secondary to the nature of the CKD5 condition of patients enrolled in the PD Z Benefits shall be covered under other applicable benefits of PhilHealth.

17. Any proposal for PhilHealth coverage to include new technologies, such as drugs/medicines and biologicals not listed in the latest Philippine National Formulary (PNF), diagnostic procedures, surgical interventions, and other treatment interventions shall consider the Health Technology Assessment Council (HTAC) recommendation.

18. PD patients currently enrolled in the Z Benefits, who underwent emergency hemodialysis, shall secure medical certification from the attending Nephrologist confirming that the patient can continue peritoneal dialysis.

19. PD patients who were declared lost to follow-up but intend to continue treatment and services for peritoneal dialysis shall be required to be assessed by the attending Nephrologist based on the criteria set in this policy if eligible to avail of this Z Benefits package.

B. Responsibilities of the Accredited PD Z Provider

1. Accredited PD Z providers shall assess all CKD5 patients requiring PD to determine their eligibility for enrollment in the Z Benefits Package for PD.

2. The accredited PD *Z* providers shall issue a PD passport (Annex D) for each patient. This document shall serve as a record of treatment for patients enrolled in this Z Benefits package.

3. The accredited PD Z provider shall ensure adequate supply of PD solutions including drugs/medicines and necessary supplies for their PD patients and maintain proper inventory to prevent stock-outs.

4. The accredited PD Z provider shall monitor the patient treatment progress, address any complications, and adjust their care plan.

5. Accredited PD Z providers are highly encouraged to conduct home visitation or telemedicine consultations to ensure that patients and their caregivers continue to follow the proper techniques and standards that should be observed during PD exchanges. These consultations will also

help assess the adequacy of dialysis and ensure that patients are correctly administering their PD solutions.

6. Accredited HFs offering dialysis should inform and educate their CKD5 patients about all available options or modalities of artificial renal replacement therapy. HFs are strongly encouraged to actively offer this modality as the first-line treatment for patients without medical contraindications to peritoneal dialysis.

7. The accredited PD Z provider shall appoint at least one (1) Z Benefits Coordinator, whose responsibilities are outlined in the existing Guiding Principles of the Z Benefits.

8. All patients under the PD Z Benefits who were shifted to hemodialysis (HD), for whatever reason, shall be subject to monitoring. HFs that provide hemodialysis services to PD patients are required to submit the list of these patients to the Benefits Administration Section (BAS) of the PhilHealth Regional Office (PRO) for endorsement to the Benefits Development and Research Department (BDRD).

9. The accredited PD Z providers are required to have a patient logbook and/or electronic medical record of all their PD patients. For standardization, the contents of the electronic medical record shall be determined by the Reference HFs and experts, subject to approval by PhilHealth.

10. The accredited PD Z providers shall maintain an electronic file record of all their patients' PD passports. These files shall serve as a data reference for validation during field monitoring of PhilHealth.

11. Coordination and collaboration with the Reference HF and among accredited PD Z Providers shall be required for operational and administrative purposes, such as, but not limited to, patient referrals, clearance from referring PD Z provider prior to transfer of patient to other PD Z providers, patient tracking, pooled procurement of PD solutions, PD trainings, and regular patient audits, among others.

12. 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. Responsibilities of the Patient

1. The patient shall adhere to the treatment plan including follow-up visits with their attending physician agreed upon with the accredited PD Z provider.

2. Patients are strictly prohibited from sharing, selling, or distributing PD solutions. They shall be aware that the PD solutions are intended for their personal use only.

3. Patients found liable for selling PD solutions shall forfeit all the privileges of availing benefits under Z, without prejudice to the filing of appropriate charges for possible violation in accordance with the existing laws, rules, and regulations. This information must be understood and agreed upon by the patient and must be explained clearly by the accredited PD Z Provider.

   The patients or guardians, in cases of pediatric patients, signify their agreement to this provision by affixing their signature or thumb mark in the ME Form (Annex C).

D. Patient Transfer

1. The accredited PD Z provider shall establish a coordinated referral process within their respective HF to ensure continuous treatment of their patients enrolled in the Z Benefits.

2. Any PD patient who wishes to transfer to another PD Z provider shall submit an original copy of the accomplished letter of intent for transfer of PD care (Annex E) to their accredited PD Z provider.

3. The referring accredited PD Z provider facilitates the completion of the letter of intent by seeking clearance from the following:
   a. Nephrologist from the referring HF
   b. Billing representative of the referring HF
   c. PD coordinator of the referring HF
   d. Head/PD coordinator of the referral HF
   e. PRO-BAS that has jurisdiction over the referring accredited PD Z provider

4. The referring accredited PD Z provider shall accomplish and submit the required documents specified in the Checklist for Patient Transfer (Annex F) to the referral PD Z provider and PRO-BAS that has jurisdiction over the referral PD Z provider.

5. The documents for patient transfer may be scanned and emailed to the respective PRO-BAS for their information and acknowledgment.

6. The remaining tranche claim for PD of the referring PD Z provider shall be paid, provided that all essential health services for PD were given and the required documents are properly accomplished.

E. Lost to Follow-up

1. The accredited PD Z provider shall exhaust all efforts to contact, navigate, or obtain information about the whereabouts or situation of their patients within sixty (60) days from the scheduled visit. In case of patients who are declared lost to follow-up or when the patient expires, the accredited PD Z provider shall file claims based on the applicable scenarios:

a. The accredited PD Z provider shall submit to PhilHealth a notarized sworn declaration that the patient is declared lost to follow-up. Claims submission of patients declared lost to follow-up shall be submitted within sixty (60) days from such declaration.

b. If the patient expires during treatment, the accredited PD Z provider 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 accredited PD Z provider shall submit their claims within sixty (60) days from the receipt of the death certificate or notarized sworn declaration issued by authorized government agencies.

2. All accredited PD Z providers shall submit a monthly report of expired patients to the BAS of the PRO. For appropriate tagging, the PRO shall endorse the list of expired PD patients or deceased members to the Member Management Group of PhilHealth.

3. To verify deaths, PhilHealth may cross-check the records with the Philippine Statistics Authority (PSA) in accordance with the existing data-sharing agreement. Claims for PD of expired or deceased patients constitute a violation of the provisions of the Revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA No. 7875 as amended by RA Nos. 9241 and 10606) and shall be dealt with accordingly.

F. Package Code, Services, Package Rates and Filing Schedule

1. The general package code for the PD Z Benefits for adult and pediatric are as follows:

Package Code	Description
Z022	PD Z Benefits Package for adults
Z023	PD Z Benefits Package for pediatric patients
Z024	Benefits Package for PD-related ancillary services

Table 1: Package Code for the Z Benefits Package for PD

2. Peritoneal Dialysis for Adults
   a. CAPD Requiring PD Bags for Adults

Package Code	Services	Package Rate Per Year (PHP)	Tranche Filing Schedule
Z022A	PD requiring three (3) 2L bags per day	389,640.00	Within 60 days after the date of

Package Code	Services	Package Rate Per Year (PHP)	Tranche Filing Schedule
		(29,972.31 per 28 days PD exchanges)	dispensing of the PD solutions
Z022B	PD requiring four (4) 2L bags per day	510,140.00 (39,241.54 per 28 days PD exchanges)	Within 60 days after the date of dispensing of the PD solutions

Table 2: Package, Services, Rate and Filing Schedule for CAPD Requiring PD Bags for Adults

b. Exit Site Infection and Peritonitis Prevention Care for Adults

Package Code	Services	Package Rate Per Year (PHP)	Tranche Filing Schedule
Z022C	Exit site infection and peritonitis prevention care	29,200.00 (Maximum of 4 episodes per year at PHP 7,300 per episode)	Within 60 days after the procedure

Table 3: Package Code, Services, Rate and Filing Schedule for Exit Site Infection and Peritonitis Prevention Care for Adults

3. Peritoneal Dialysis for Pediatric Patients
   a. CAPD Requiring PD Bags for Pediatric Patients

Package Code	Services	Package Rate Per Year (PHP)	Tranche Filing Schedule
Z023A	PD requiring four (4) 2L bags per day	510,140.00 (39,241.54 per 28 days PD exchanges)	Within 60 days after the date of dispensing of the PD solutions
Z023B	PD requiring five (5) 2L bags per day	637,676.00 (49,052 per 28 days PD exchanges)	Within 60 days after the date of dispensing of the PD solutions

Package Code	Services	Package Rate Per Year (PHP)	Tranche Filing Schedule
Z023C	PD requiring six (6) 2L bags per day	765,210.00 (58,862.31 per 28 days PD exchanges)	Within 60 days after the date of dispensing of the PD solutions

Table 4: Package Code, Services, Rate and Filing Schedule for CAPD Requiring PD Bags for Pediatric Patient

b. APD Requiring PD Bag for PD Pediatric Patients

Package Code	Services	Package Rate Per Year (PHP)	Tranche Filing Schedule
Z023D	PD requiring one (1) 5L bags per day	763,000.00 (58,692.31 per 28 days PD exchanges)	Within 60 days after the date of dispensing of the PD solutions
Z023E	PD requiring two (2) 5L bags per day	1,016,000.00 (78,153.85 per 28 days PD exchanges)	Within 60 days after the date of dispensing of the PD solutions
Z023F	PD requiring three (3) 5L bags per day	1,269,000.00 (97,615.38 per 28 days PD exchanges)	Within 60 days after the date of dispensing of the PD solutions

Table 5: Package Code, Services, Rate and Filing Schedule for APD Requiring PD Bag for PD Pediatric Patients

c. Exit Site Infection and Peritonitis Prevention Care for Pediatric Patients

Package Code	Services	Package Rate Per Year (PHP)	Filing Schedule
Z023G	Exit site infection and peritonitis prevention care	16,800.00 (1,400 per month)	Within 60 days after the procedure

Table 6: Package Code, Services and Rate for Exit Site Infection and Peritonitis Prevention Care for Pediatric Patients

4. Benefits Package for PD-Related Ancillary Services
   a. PD Catheter Insertion and Initiation for Adults and Pediatric Patients

Package Code	Services	Package Rate (PHP)	Filing Schedule
Z024A	PD Catheter Insertion and Initiation	71,500.00	Within 60 days after the procedure, if outpatient, or within 60 days after discharge, if admitted

Table 7: Package Code, Services, Rate, and Tranche Filing Schedule for PD Catheter Insertion and Initiation for Adults and Pediatric Patients

b. Outpatient Treatment of PD-related Peritonitis for Adults and Pediatric Patients

Package Code	Services	Package Rate (PHP)	Filing Schedule
Z024B	Outpatient treatment of PD-related peritonitis	25,000.00 (once per year)	Within 60 days after the procedure

Table 8: Package Code, Services, Rate, and Tranche Filing Schedule for Outpatient Treatment of PD-related Peritonitis for Adults and Pediatric Patients

c. Laboratory/Diagnostics and Drugs/Medicines for PD Adults and Pediatric Patients

Package Code	Services	Package Rate Per Year (PHP)	Filing Schedule
Z024C	Laboratory/ Diagnostic tests and Drugs/ Medicines	75,360 (6,280 per month)	Within 60 days after the end of the applicable month

Table 9: Package Code, Services and Rate for Laboratory/ Diagnostic Tests and Drugs / Medicines for Adults and Pediatric Patients

G. Claims Filing and Reimbursement

1. The accredited PD Z provider shall deliver all of the essential health services offered in each benefits package as a requirement for filing of claims.

2. The accredited PD Z provider shall ensure at all times the accuracy and completeness of the forms or documents submitted to PhilHealth.

3. Claim Form 1 or PBEF shall be submitted for the initial claims application for reimbursement. The list of documentary requirements for claims filing per service is provided in the Checklist of Requirements for Reimbursement (Annex G).

4. Payments shall be in tranches and shall be given directly to the accredited PD Z provider. Every tranche payment covers the prescribed number of PD exchanges for 28 days.

5. Claims for drugs/medicines, laboratory and diagnostic tests shall be filed separately from the PD exchanges on a monthly basis.

6. The accredited PD Z provider 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).

7. The accredited PD Z provider shall follow existing guidelines of the SOA[14] requirement for claims submission under the Z Benefits.

8. In the event that the PD patient is admitted to an accredited HF for service provisions other than peritoneal dialysis, the tranche claim for PD shall be paid, provided that all essential health services for PD were given, and the required tranche documents are properly accomplished

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

and submitted to PhilHealth. Claims for PD should not be filed as 2nd case rate.

Accredited HFs should allow patients under the PD Z Benefits to bring in their PD solutions during confinement. If patients cannot bring their PD solutions, the HF should discuss with the patients and/or their family all options to continue the PD exchanges while admitted in the hospital.

Sample scenario:
A PD Z patient was admitted from December 15 - 20 due to pneumonia. The inclusive dates of the 12th tranche of PD exchanges of the patient are from December 1 to 31. The claims of the patient for pneumonia shall be filed as a separate claim from the PD exchanges.

9. In the event that a patient under the PD Z Benefits is confined in an accredited HF and would need to be shifted to hemodialysis (HD), the tranche claim for PD shall be paid, provided that, all essential health services for PD were provided and the required tranche documents are complete and properly accomplished when submitted to PhilHealth.

10. Accredited PD Z providers 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.

L. Claims Payment and Evaluation

1. PhilHealth shall reimburse covered services under this Z Benefits package following the predetermined package rates or case-based payment, except for drugs or medicines, laboratory tests, and diagnostics procedures.

2. Reimbursement for drugs or medicines, laboratory tests, and diagnostics procedures shall be based on the actual amount as reflected in the SOA or its equivalent and shall not exceed the amount indicated in Table 9.

3. PhilHealth shall review the completeness of all forms submitted by the accredited PD Z providers. The PROs and LHIOs shall have the prerogative not to accept incomplete documents. However, they should directly coordinate with the Z Benefits coordinator regarding the deficiencies in the documents submitted. Once the documents are complete, the accredited PD Z provider shall submit these to PhilHealth for payment of claims within the required filing schedule.

4. PhilHealth shall apply the "return to sender" (RTS) policy for claims documents with incomplete data or documentary requirements. However, inconsistencies in data or information contained in the documents or non-provision of an essential health service are grounds for automatic denial of the claim.

   Upon receipt of the notice of RTS, the accredited PD Z provider shall comply with the deficiencies within the prescribed period based on the existing rules and regulations set by PhilHealth.

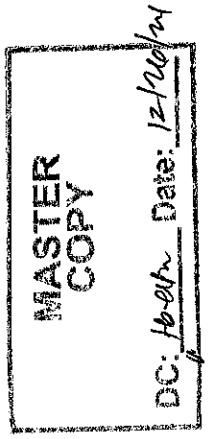
5. PhilHealth shall have the right to subject any or all claims to medical review before and/or after payment or reimbursement of the accredited providers, following the existing guidelines.

6. PhilHealth shall process succeeding claims without reference to any prior tranche or service. Claims for each service within the same date or period shall not be considered overlapping claims.

7. PhilHealth shall pay the tranche claim for PD patients confined or shifted to hemodialysis, provided that all essential health services were rendered.

8. When the patient expires or is declared lost to follow-up, PhilHealth shall only reimburse the corresponding amount of the services rendered by the accredited PD Z provider.

9. Any change of member/patient category upon enrollment shall not affect the claims filed by the accredited PD Z provider.



10. 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.

11. PhilHealth shall process all claims submitted by the accredited provider within thirty (30) working days upon receipt of claims applications, provided that the mandatory documents and attachments are complied with.

12. Claims filed by the accredited provider shall be denied based on the following instances:

a. If a essential health service was not provided by the accredited provider;
b. Late filing;
c. Not registered in the PDD registry or no PDD registry matrix submitted.
d. Inconsistency of data and information contained in the claims application.

M. Monitoring

1. PhilHealth shall enforce current policies and guidelines on monitoring the performance of accredited PD Z providers in implementing the Z Benefits Package for Peritoneal Dialysis 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 Peritoneal Dialysis, 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 concerns about the implementation of the Z Benefits policy or their experience with benefit availment to the Corporate Action Center (CAC) via the hotline (02) 8862-2588 or email actioncenter@philhealth.gov.ph.

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

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.

N. 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.

O. 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.

P. Annexes (Posted on the official website of PhilHealth)

Annex A: Checklist of Eligibility Criteria for PD Z Benefits
- Annex A.1: Checklist of Eligibility Criteria for PD Z Benefits - Adult
- Annex A.2: Checklist of Eligibility Criteria for PD Z Benefits - Pediatric

Annex B: List of Essential Health Services for PD
- Annex B.1: List of Essential Health Services for PD Z Benefits - Adult
- Annex B.2: List of Essential Health Services for PD Z Benefits - Pediatric
- Annex B.3: List of Essential Health Services PD Z Benefits - PD-Related Ancillary Services

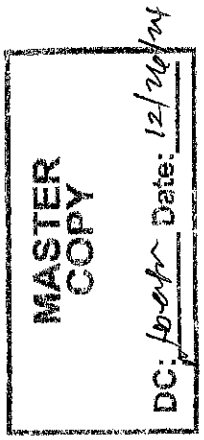
Annex C: Member Empowerment (ME) Form

Annex D: Peritoneal Dialysis (PD) Passport

Annex E: Letter of Intent for Transfer of PD Care

Annex F: Checklist for Patient Transfer

Annex G: Checklist of Requirements for Reimbursement
- Annex G.1: Checklist of Requirements for Reimbursement for PD Z Benefits - Adult
  - Annex G.1A: Checklist of Requirements for Reimbursement Using CAPD - PD Bags
  - Annex G.1B: Checklist of Requirements for Reimbursement - Exit site infection and peritonitis prevention care
- Annex G.2: Checklist of Requirements for Reimbursement for PD Z Benefits - Pediatric
  - Annex G.2A: Checklist of Requirements for Reimbursement Using CAPD - PD Bags
  - Annex G.2B: Checklist of Requirements for Reimbursement Using APD - PD Bags
  - Annex G.2C: Checklist of Requirements for Reimbursement for PD Z Benefits for Adult -Exit site infection and peritonitis prevention care
- Annex G.3: Checklist of Requirements for Reimbursement for the Benefits Package for PD-Related Ancillary Services



Annex G.3A: Checklist of Requirements for Reimbursement for the Benefits Package for PD-Related Ancillary Services - PD Catheter Insertion and Initiation for Adults and Pediatric Patients

Annex G.3B: Checklist of Requirements for Reimbursement for the Benefits Package for PD-Related Ancillary Services - Outpatient Treatment of PD-related Peritonitis for Adults and Pediatric Patients

Annex G.3C: Checklist of Requirements for Reimbursement for the Benefits Package for PD-Related Ancillary Services - Laboratory/ Diagnostic Tests and Drugs/ Medicines for Adults and Pediatric Patients

Annex H: Z Satisfaction Questionnaire

Annex I: Checklist of Essential Health Services

Annex I.1: Checklist of Essential Health Services for PD Z Benefits - Adult

Annex I.1A: Checklist of Essential Health Services Using CAPD - PD Bags

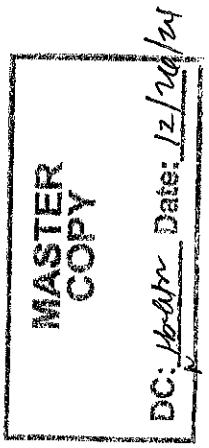
Annex I.1B: Checklist of Essential Health Services - Exit site infection and peritonitis prevention care

Annex I.2: Checklist of Essential Health Services for PD Z Benefits - Pediatric

Annex I.2A: Checklist of Essential Health Services Using CAPD - PD Bags

Annex I.2B: Checklist of Essential Health Services Using APD - PD Bags

Annex I.2C: Checklist of Essential Health Services for PD Z Benefits for Adult - Exit site infection and peritonitis prevention care



Annex I.3: Checklist of Essential Health Services for Benefits Package for PD-Related Ancillary Services

Annex I.3A Checklist of Essential Health Services for Benefits Package for PD-Related Ancillary Services - PD Catheter Insertion and Initiation for Adults and Pediatric Patients

Annex I.3B Checklist of Essential Health Services for Benefits Package for PD-Related Ancillary Services - Outpatient

	Treatment of PD-related Peritonitis for Adults and Pediatric Patients
Annex I.3C	Checklist of Essential Health Services for Benefits Package for PD-Related Ancillary Services - Laboratory/ Diagnostic Tests and Drugs / Medicines for Adults and Pedia

Annex J: Accreditation and Contracting Peritoneal Dialysis (PD) Z Benefits Providers

Annex K: Transmittal Form

Annex L: Home Visit Questionnaire

IV. 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).

V. TRANSITORY CLAUSE

A. Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to accredited PD Z providers 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. While the necessary system is being developed, the accredited PD Z providers shall submit the claims manually. PhilHealth shall issue a corresponding advisory to inform the health facilities once the benefits package is fully integrated into the system.

C. The accredited PD Z provider may resubmit a new pre-authorization request 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. 2016-0021 "PD First" Z Benefits: The Z Benefits for End-Stage Renal Disease Requiring Peritoneal Dialysis (Revision 1" and PC No. 2021-0022 "The Guiding Principles of the Z Benefits (Revision 1)."

E. The Health Finance Policy Sector shall conduct pilot testing of the benefits package for the implementation of automated peritoneal dialysis (APD) in selected health facilities within one year from the effective date of this policy. PhilHealth shall disseminate the guidelines for the conduct of pilot tests.

VI. SEPARABILITY CLAUSE

In the event that 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.

VII. REPEALING CLAUSE

This PhilHealth Circular repeals specific provisions relevant to peritoneal dialysis under PC No. 2016-0021 ["PD First" Z Benefits: The Z Benefits for End-Stage Renal Disease Requiring Peritoneal Dialysis (Revision 1)] and specific provisions on PC No. 2021-0022 [The Guiding Principles of the Z Benefits (Revision 1)].

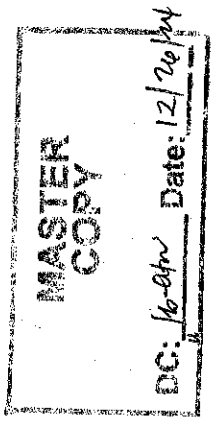
All other PhilHealth Circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

VIII. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on January 1, 2025, 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.

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

Date signed: 12/23/24



Annex A.1: Checklist of Eligibility Criteria for Peritoneal Dialysis - Adult

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PhilHealthOfficial teamphilhealth

Case No._____

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

PDD Registry No.	
Date of Registration (mm/dd/yyyy)	

Place a (✓) in the box and provide appropriate response/s

History of Previous Dialysis Treatment ☐ Not Applicable	Date of Last Session (mm/dd/yyyy)
With ongoing dialysis session ☐ Yes ☐ No	
If yes, indicate the mode of dialysis: ☐ PD ☐ HD	

Place a (✓) if "Yes"

General Criteria	**YES**
The patient must be at least 19 y/o and above at the time of enrollment to the PD Z package	

Place a (✓) if "Yes"

	Continuous Ambulatory Peritoneal Dialysis (CAPD)	**YES**
1.	Diagnosed with Chronic Kidney Disease (CKD) Stage 5 requiring renal replacement therapy [does not include those requiring only temporary dialysis for acute kidney injury (e.g. dialysis for leptospirosis)]	
2.	Has a permanent peritoneal dialysis catheter properly placed in the abdominal cavity	

Continuous Ambulatory Peritoneal Dialysis (CAPD)	YES
3. Has completed PD initiation in an accredited health facility or accredited PD Z benefits provider	
4. No longer uremic, with stable vital signs	
5. Patients and/or a caregiver have adequate training to perform PD at home using MANUAL exchanges.	
6. Absence of any disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen	
7. Absence of any inflammatory bowel diseases (Crohns' disease, ulcerative colitis or diverticulitis)	
8. Absence of any intra-abdominal tumors or intestinal obstruction	
9. Absence of active serositis	
10. Absence of known or suspected allergy to PD solutions	

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

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DC: Yes Date: 12/2016

Annex A.2: Checklist of Eligibility Criteria for Peritoneal Dialysis - Pediatric

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Case No._____

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

PDD Registry No.	
Date of Registration (mm/dd/yyyy)	

Place a (✓) in the box and provide appropriate response/s

History of Previous Dialysis Treatment ☐ Not Applicable	Date of Last Session (mm/dd/yyyy)
Ongoing Dialysis Session ☐ Yes ☐ No If yes, indicate the mode of dialysis: ☐ PD ☐ HD	

Place a (✓) if "Yes"

General Criteria	**YES**
1. The patient must be aged 0 to 18 years old and 364 days	
2. Written informed consent from the parents or legal guardian is secured.	

Place a (✓) if "Yes"

Continuous Ambulatory Peritoneal Dialysis (CAPD) / Automated Peritoneal Dialysis (APD)	**YES**
1. Diagnosed with Chronic Kidney Disease (CKD) Stage 5 requiring renal replacement therapy [does not include those requiring only temporary dialysis for acute kidney injury (e.g. dialysis for leptospirosis)]	
2. Has a permanent peritoneal dialysis catheter properly placed in the abdominal cavity	

Continuous Ambulatory Peritoneal Dialysis (CAPD) / Automated Peritoneal Dialysis (APD)	YES
3. Has completed PD initiation in an accredited health facility or accredited PD Z benefits provider	
4. Patients and/or a parents or caregiver have adequate training to perform PD at home.	
5. Absence of known or suspected allergy to PD solutions	

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

MASTER COPY
DC: Date: 12/16/14

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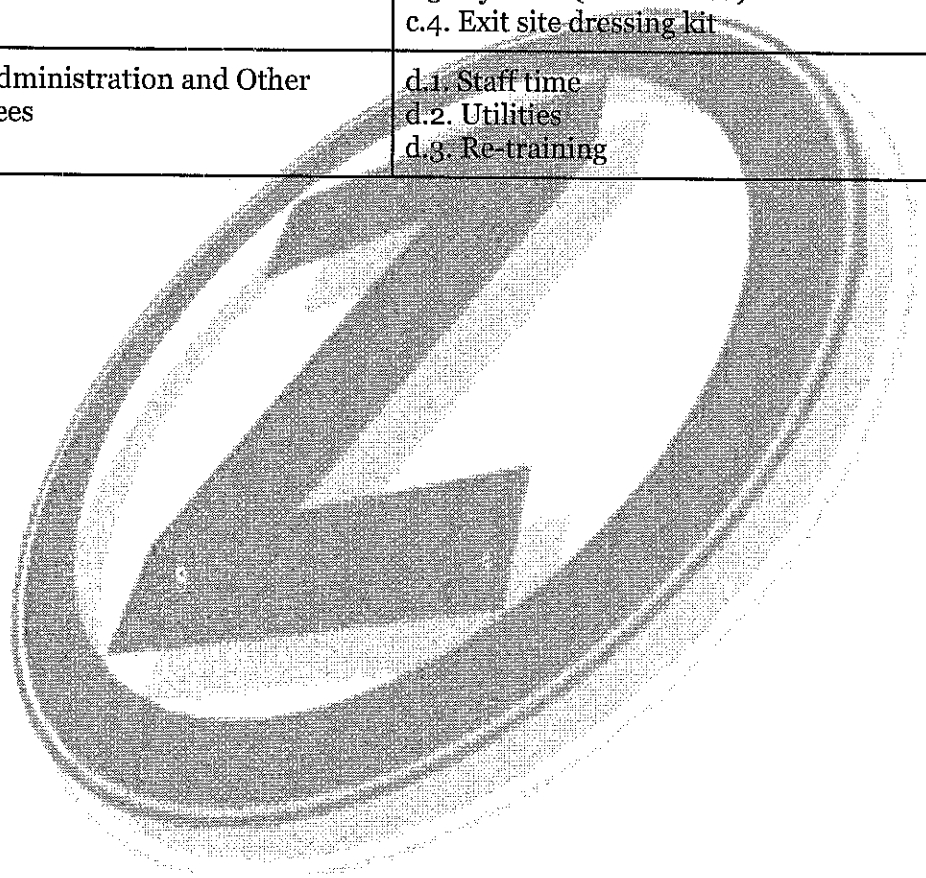
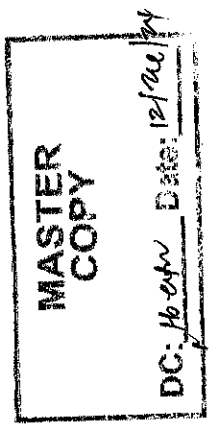
List of Essential Health Services for PD First Z Benefits for Adult

Essential Health Services	
1. Continuous Ambulatory Peritoneal Dialysis (CAPD)	
a. PD Solutions	PD Solutions, 2 Liter bags (1.5%, 2.3% or 2.5%, 4.25% dextrose or their equivalent) with disinfection cap a.1 (3) 2L bags / day a.2 (4) 2L bags / day
b. Supplies and Commodities	b.1. PD Transfer set [two (2) per calendar year] b.2. PD Adapter b.3. PD Clamp b.4. Topical antiseptic spray
c. Administration and Other Fees	c.1. Monthly monitoring and follow-up visits c.2. CAPD Training c.3. Staff time c.4. Utilities
2. Exit Site Infection and Peritonitis Prevention Care	
a. Laboratory, Diagnostic and Imaging	a.1. CBC a.2. Creatinine a.3. Sodium a.4. Potassium a.5. Calcium a.6. Albumin a.7. Scout film of abdomen (as indicated) a.8. Exit site discharge gram stain (GS) and culture and sensitivity (CS) (as indicated)
b. Procedures and Services	Consultation/ Visit

Essential Health Services	
c. Medicines, Supplies and Commodities	c.1. Antibiotics c.2. Mupirocin or its equivalent c.3. Nystatin (as indicated) c.4. Exit site dressing kit
d. Administration and Other Fees	d.1. Staff time d.2. Utilities d.3. Re-training





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List of Essential Health Services for PD First Z Benefits - Pediatric Patients

Essential Health Services	
1. Continuous Ambulatory Peritoneal Dialysis (CAPD)	
a. PD Solutions	a.1. PD Solutions, 2 Liter bags (1.5%, 2.3% or 2.5%, 4.25% dextrose or their equivalent) with disinfection cap a.1.a. (4) 2L bags/day a.1.b. (5) 2L bags/day a.1.c. (6) 2L bags/day
b. Supplies and Commodities	b.1. PD Transfer set [two (2) per calendar year] b.2. PD Adapter b.3. PD Clamp b.4. Topical antiseptic spray
c. Administration and Other Fees	c.1. Monthly monitoring and follow-up visits c.2. CAPD Training c.3. Staff time c.4. Utilities
2. Automated Peritoneal Dialysis (APD)	
a. PD Solutions	a.1. PD Solutions, 5 Liter bags (1.5%, 2.3% or 2.5%, 4.25% dextrose or their equivalent) a.1.a. (1) 5L bags/day a.1.b.(2) 5L bags/day a.1.c. (3) 5L bags/day
b. Supplies and Commodities	b.1. APD Cassette b.2. APD Drain bag
d. Administration and Other Fees	c.1. Monthly monitoring and follow-up visits c.2. PD Training c.3. Staff time c.4. Utilities

Essential Health Services	
3. Exit Site Infection and Peritonitis Prevention Care	
a. Laboratory, Diagnostic and Imaging	a.1. CBC a.2. Creatinine a.3. Sodium a.4. Potassium a.5. Calcium a.6 Albumin a.7. Scout film of abdomen (as indicated) a.8. Exit site discharge gram stain (GS) and culture and sensitivity (CS) (as indicated)
b. Procedures and Services	b.1. Consultation/ Visit
c. Medicines, Supplies and Commodities	c.1. Antibiotics c.2. Mupirocin or its equivalent c.3. Nystatin (as indicated) c.4. Exit site dressing kit
d. Administration and Other Fees	d.1. Staff time d.2. Utilities d.3. Re-training

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List of Essential Health Services for PD-related Ancillary Services for Adult and Pediatric Patients

Essential Health Services	
1. PD Catheter Insertion and Initiation	
a. Laboratory and Diagnostic Tests (as indicated)	a.1. Complete blood count (CBC) a.2. Creatinine a.3. Sodium a.4. Potassium a.5. Calcium a.6. Albumin a.7. Phosphorous a.8. Protime a.9. Partial thromboplastin time a.10.ECG a.11.Chest X-Ray a.12.Scout film of abdomen
b. Procedure*	b.1. PD catheter insertion b.2. PD Initiation
c. Medicines (as indicated)	c.1.PD solutions (2L) or (5L) bags c.2. Calcium gluconate c.3. Sodium bicarbonate c.4. Amlodipine c.5. Non-calcium-based phosphate binders (e.g. sevelamer 800mg/tab) c.6. Angiotensin receptor blocker or ACE-inhibitor c.7. Ferrous sulfate c.8. Folic acid c.9. Erythropoietin c.10.Enema c.11. Lactulose c.12. Mupirocin c.13. Potassium (IV) c.14. Calcium (IV)

Essential Health Services	
d. Supplies and Commodities (as indicated)	d.1. Normal saline solution d.2. PD solution 2.0 liter per bag (1.5%, 2.3% or 2.5%, 4.25% dextrose or their equivalent) and 5 liters per bag for cycler d.3. (1) PD transfer set d.4. (1) PD adapter d.5. (1) PD clamp d.6. PD drain bag d.7. Automated PD** for initiation (total of up to 40 exchanges of up to 1.5L/exchange or up to a maximum of 12 x 5L PD bags depending on baseline BUN, creatinine prior to CAPD training) including automated PD set with cassette 4-prong d.8. PD catheter (up to 2)
e. Administration and Other Fees	e.1. PD training e.2. Staff time e.3. Operating room (OR) fee e.4. Room and board e.5. Utilities
2. Outpatient Treatment of PD-related Peritonitis	
a. Laboratory and Diagnostic Tests (once only)	a.1. CBC a.2. Creatinine a.3. Sodium a.4. Potassium a.5. Calcium a.6. Albumin a.7. Scout film of abdomen a.8. Dialysate effluent cell count a.9. Dialysate effluent culture and sensitivity (CS)
b. Procedure/ Services	Consultation/visit
c. Medicine, Supplies and Commodities	c.1. Antimicrobials (e.g. vancomycin 1g/vial, amikacin 250mg or 500mg/vial) c.2. Heparin 1,000IU/mL, 5 mL vial c.3. Mupirocin or its equivalent c.4. Nystatin (as indicated) c.5. Medical supplies
d. Administration and Other Fees	d.1. Staff time d.2. Utilities d.3. Re-training
3. Laboratory/Diagnostics and Drugs/Medicines	

Essential Health Services	
a. Laboratory / Diagnostic Tests (As indicated)	Monthly Adult and pediatric patient 1.1. CBC 1.2. BUN 1.3. Creatinine 1.4. Potassium 1.5. Calcium 1.6. Phosphorus Applicable for pediatric patients 1.7. Sodium 1.8. Magnesium Quarterly Adult and pediatric patient 1.9. Uric acid 1.10. Albumin Adult 1.11. Fasting blood sugar (FBS) or random blood sugar (RBS) Pediatric patients 1.12. 25-OH vitamin D 1.13. iPTH 1.14. Alkaline phosphatase 1.15. Serum iron 1.16. Total iron binding capacity (TIBC) 1.17. Ferritin Twice per year Adult 1.18. HBsAg 1.19. Anti-HCV Pediatric patients (every six (6) months) 1.20. Peritoneal equilibrium test *** Adult (as necessary) 1.22. HBA1c
b. Drugs / Medicines	
1. Drugs / Medicines (as indicated)	Adult and Pediatric Patients 2.1. Erythropoietin - stimulating agents (e.g. erythropoietin (epoetin) alpha, epoetin beta)

Essential Health Services	
	2.2. Calcitriol 0.25mcg/cap 2.3. Cholecalciferol 800 IU/cap 2.4. Iron supplements oral 325mg/tab 2.5. IV iron 20mg/ml 5ml amp 2.6. Calcium-based phosphate binders 500mg/tab 2.7. Non-calcium-based phosphate binders (e.g. sevelamer) 800mg/tab 2.8. Mupirocin or its equivalent 2.9. Topical antiseptic spray

*Can avail prior to the enrollment to the PD Z Benefits package in an Accredited PD Z provider
**For accredited PD Z providers with PD cycler machines
***For pilot testing at selected accredited PD Z providers

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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.

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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DC: Hdmv Date: 12/ne/24

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.*	

MASTER COPY Date: 12/10/24

D. Edukasyon ng Miyembro ***D. Member Education***		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi naaukol *Put a check mark (√) opposite appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. *My health care provider explained the nature of my condition/disability.*		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon [d] *My health care provider explained the treatment options/intervention[d].* [d] Para sa ZMORPH, ito ay ukol sa pangangailangan ng pagbibigay at rehabilitasyon para sa pre at post-device. *[d] For ZMORPH, this refers to the need for pre- and post-device provision and rehabilitation.*		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/ masamang epekto ng gamutan/ interbensyon. *The possible side effects/adverse effects of treatment/intervention were explained to me.*		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon. *My health care provider explained the mandatory services and other services required for the treatment of my condition/intervention.*		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. *I am satisfied with the explanation given to me by my health care provider*		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. *I have been fully informed that I will be cared for by all the pertinent medical and allied specialties, as needed, present in the PhilHealth contracted 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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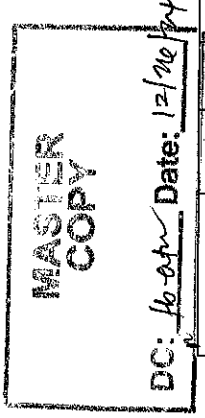
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol Put a check mark(√) opposite appropriate answer or NA if not applicable.	OO YES	HINDI NO
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/s of my follow-up visit/s.*		
9. Ipinaalam 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.		

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.		

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.*		

E. Tungkulin at Responsabilidad ng Miyembro ***E. Member Roles and Responsibilities***		
Lagyan ng (√) ang angkop na sagot o NA kung hindi naaukol *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)*



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 D: Peritoneal Dialysis (PD) Passport

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)	DATE OF CONSULTATION (mm/dd/yyyy)
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

PD PASSPORT

The PD Coordinator should countersign the availment of the PD bags opposite the inclusive dates.

Claim No.	Date of PD dispensing	Inclusive dates	No. of issued bags/day	Pharmacist's signature	Date of next claim	Patient's signature	Attending Physician's signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
		PD transfer set given*	☐ Date (mm/dd/yyyy) _____				
			☐ Date (mm/dd/yyyy) _____				

* Quantity: 2 per calendar year, every six (6) months only

Medications as indicated (Attach additional sheets as necessary)

Name of medicine	Dosage	Preparation	Date given	Patient's/ parent/ guardian's signature	Attending Physician's signature

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Annex E: Letter of Intent for Transfer of PD Care

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

DATE (mm/dd/yyyy)
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

LETTER OF INTENT FOR TRANSFER OF PD CARE TO A REFERRAL PD Z PROVIDER

This is to certify that I, _____, born on _____,
(Name of Patient) *(Date of Birth)*
age _____ years old, residing at _____,
(Address)
was diagnosed with CKD Stage 5 and was initiated on peritoneal dialysis at the
_____ on _____.
(Name of Referring PD Z Provider) *(Date of PD Initiation)*

I perform _____ exchanges per day. I would like to request for transfer of PD Care to
(indicate number)
_____ under the care of _____.
(Name of Referral PD Z Provider) *(Name of Nephrologist)*

I understand that upon transfer to a referral PD Z provider, I will have to surrender my PD Passport to the PD Coordinator of my referring PD Z provider as well as waive all my subsequent PD claims in my referring PD Z provider. In case I decide to return to the referring PD Z provider to resume my PD care, I will have to abide by the policies set by them as a new PD patient.

Conforme by:	Certified correct by:
(Printed name and signature) Patient/ Parent/ Guardian	(Printed name and signature) Nephrologist, Referring PD Z Provider
	PhilHealth Accreditation ☐☐☐☐ - ☐☐☐☐☐☐ - ☐

Certified correct by:	Certified correct by:
(Printed name and signature) Billing Representative, Referring PD Z Provider	(Printed name and signature) PD Coordinator, Referring PD Z Provider

Acknowledged by:	Acknowledged by:
(Printed name and signature) Head/PD Coordinator Referral PD Z Provider	(Printed name and signature) BAS Head/Authorized Representative PhilHealth Regional Office ____ of the Referring Accredited PD Z Provider
	Acknowledged by:
	(Printed name and signature) BAS Head/Authorized Representative PhilHealth Regional Office ____ of the Referral Accredited PD Z Provider

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Annex F: Checklist for Patient Transfer - PD Z Benefits

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
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CHECKLIST FOR PATIENT TRANSFER – PD Z Benefits

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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

For HF PD patients* who will be transferred to a referral PD Z Provider, the following checklist shall be accomplished:

NAME OF REFERRAL PD Z PROVIDER:
ADDRESS OF REFERRAL PD Z PROVIDER:

	Requirements	Yes OR No (tick appropriate box)	Signature of Responsible Person
1.	Updated Medical Abstract	☐ Yes ☐ No	Name & signature Attending Nephrologist
2.	Updated PD Prescription for one (1) month	☐ Yes ☐ No	
3.	Letter of Referral from Attending Nephrologist/ Fellow	☐ Yes ☐ No	
4.	Clearance from PD Z Provider re: status of utilization of PhilHealth PD First Z Benefits Claims	☐ Yes ☐ No	Name & signature Billing Personnel
5.	Letter of Intent from Patient requesting for transfer to a referral PD Z Provider (Annex E)	☐ Yes ☐ No	Name & signature Patient/Parent/Guardian
6.	Submission of PD Passport (Annex D) to Provider	☐ Yes ☐ No	Name & signature PD Coordinator

*HF PD Patients are those who had their PD initiation and subsequent follow-ups in the referring PD Z Provider. They claim their PD First Z Benefits from the referring HF.

Certified complete by:	Conforme by:
_____ Printed name and signature PD Coordinator	_____ Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Annex G.1A: Checklist of Requirements for Reimbursement Using CAPD - Adult

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 Using CAPD - PD Bags for Adult

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

REQUIREMENTS	Status
I. Upon filing of claims for the 1st tranche	
A. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
B. Photocopy of the completely accomplished Checklist of Eligibility Criteria (Annex A.1)	
C. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex C)	
II.To be submitted every filing of tranche (every 28 days)	
A. Transmittal Form (Annex K)	
B. Photocopy of PD passport (Annex D)	
C. Accomplished Checklist of Requirements for Reimbursement (Annex G.1A.)	
D. Accomplished Checklist of List of Essential Health Services Using CAPD - PD Bags (Annex I.1A)	
E. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
III.To be submitted along with the claims for the 13th tranche	
Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

MASTER COPY Date: 12/10/24

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	☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Certified correct by:*	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Nephrologist	(Printed name and signature) Please tick appropriate box ☐ Head, Peritoneal Dialysis Unit OR ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

*for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.

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Annex G.1B: Checklist of Requirements For Reimbursement - Exit Site Infection and Peritonitis Prevention Care - Adult

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 - Exit site infection and Peritonitis Prevention Care - Adult

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

	REQUIREMENTS	Status
A.	Transmittal Form (Annex K)	
B.	Accomplished Checklist of Requirements for Reimbursement (Annex G.1B)	
C.	Properly accomplished Claim form (CF) 2	
D.	Photocopy of PD passport (Annex D)	
E.	Accomplished Checklist of Essential Health Services for Exit Site Infection and Peritonitis Prevention Care (Annex I.1B)	
F.	Original or Certified true copy (CTC) of the Statement of Account (SOA)	
G.	Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)		
Date Filed (mm/dd/yyyy)		

Certified correct by:*	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Nephrologist	(Printed name and signature) Please tick appropriate box ☐ Head, Peritoneal Dialysis Unit OR ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

*for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.

MASTER COPY DC: Date: 12/ne/24

Annex G.2A: Checklist of Requirements for Reimbursement Using CAPD - Pediatric

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 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 Using CAPD - PD Bags for Pediatric Patients

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

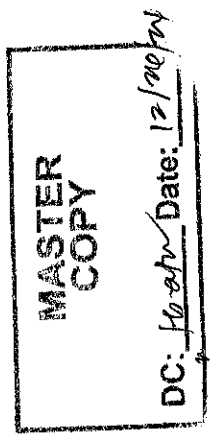
REQUIREMENTS	Status
I. Upon filing of claims for the 1st tranche	
A. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
B. Photocopy of the completely accomplished Checklist of Eligibility Criteria (Annex A.2)	
C. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex C)	
II. To be submitted every filing of tranche (every 28 days)	
A. Transmittal Form (Annex K)	
B. Photocopy of PD passport (Annex D)	
C. Accomplished Checklist of Requirements for Reimbursement (Annex G.2A)	
D. Accomplished Checklist of Essential Health Services Using CAPD - PD Bags (Annex I.2A)	
E. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
III. To be submitted along with the claims for the 13th tranche	
Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

DC: Heather Date: 12/10/24

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	☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Certified correct by:*	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Pediatric Nephrologist	(Printed name and signature) Please tick appropriate box
PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐☐	☐ Head, Peritoneal Dialysis Unit OR
Date signed (mm/dd/yyyy)	☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐☐
	Date signed (mm/dd/yyyy)

*for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.



Annex G.2B: Checklist of Requirements for Reimbursement Using APD - Pediatric

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 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 Using APD - PD Bags for Pediatric Patients

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

REQUIREMENTS	Status
I. Upon filing of claims for the 1st tranche	
A. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF2	
B. Photocopy of the completely accomplished Checklist of Eligibility Criteria (Annex A.2)	
C. Photocopy of completely accomplished Member Empowerment (ME) Form (Annex C)	
II. To be submitted every filing of tranche (every 28 days)	
A. Transmittal Form (Annex K)	
B. Photocopy of PD passport (Annex D)	
C. Accomplished Checklist of Requirements for Reimbursement (Annex G.2B)	
D. Accomplished Checklist of Essential Health Services Using CAPD - PD Bags (Annex I.2B)	
E. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
III.To be submitted along with the claims for the 13th tranche	
Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

MASTER COPY
DC: Date: 12/06/24

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	☐☐ - ☐☐☐☐☐☐☐☐ - ☐

Certified correct by:*	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Pediatric Nephrologist	(Printed name and signature) Please tick appropriate box
PhilHealth Accreditation No. ☐☐ - ☐☐☐☐☐☐☐☐ - ☐☐	☐ Head, Peritoneal Dialysis Unit OR
Date signed (mm/dd/yyyy)	☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐ - ☐
	Date signed (mm/dd/yyyy)

*for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.

MASTER COPY
DC: Hospv Date: 12/10/04

Annex G.2C: Checklist of Requirements For Reimbursement - Exit Site Infection and Peritonitis Prevention Care – Pedia

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 - Exit site infection and Peritonitis Prevention Care – Pediatric Patient

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

	REQUIREMENTS	Status
A.	Transmittal Form (Annex K)	
B.	Accomplished Checklist of Requirements for Reimbursement (Annex G.2C)	
C.	Properly accomplished Claim form (CF) 2	
D.	Photocopy of PD passport (Annex D)	
E.	Accomplished Checklist of Essential Health Services for Exit Site Infection and Peritonitis Prevention Care (Annex I.2C)	
F.	Original or Certified true copy (CTC) of the Statement of Account (SOA)	
G.	Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)		
Date Filed (mm/dd/yyyy)		

Certified correct by:*	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Pediatric Nephrologist	(Printed name and signature) Please tick appropriate box ☐ Head, Peritoneal Dialysis Unit OR ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation No. ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

*for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.

MASTER COPY DC: Date: 12/09/24

Annex G.3A: Checklist of Requirements For Reimbursement – PD-related Ancillary Services (PD Catheter Insertion and Initiation)

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 – PD-related Ancillary Services (PD Catheter Insertion and Initiation)

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

REQUIREMENTS	Status
A. Transmittal Form (Annex K)	
B. Accomplished Checklist of Requirements for Reimbursement (Annex G.3A)	
C. Properly accomplished Claim form (CF) 2	
D. Photocopy of PD passport (Annex D)	
E. Accomplished Checklist of Essential Health Services for PD-related Ancillary Services – PD Catheter Insertion and Initiation (Annex I.3A)	
F. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
G. Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

Certified correct by:**	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Nephrologist	(Printed name and signature) Please tick appropriate box ☐ Head, Peritoneal Dialysis Unit OR ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
PhilHealth Accreditation ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐	PhilHealth Accreditation ☐☐☐☐☐ - ☐☐☐☐☐☐☐ - ☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

**for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.

MASTER COPY DC: Jenny Date: 12/Nov/24

Annex G.3B: Checklist of Requirements For Reimbursement – PD-related Ancillary Services Outpatient Treatment of PD-related Peritonitis

PhilHealth
Your Partner in Health
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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 – PD-related Ancillary Services (Outpatient Treatment of PD-related Peritonitis)

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

REQUIREMENTS	Status
A. Transmittal Form (Annex K)	
B. Accomplished Checklist of Requirements for Reimbursement (Annex G.3B)	
C. Properly accomplished Claim form (CF) 2	
D. Photocopy of PD passport (Annex D)	
E. Accomplished Checklist of Essential Health Services for PD-related Ancillary Services – Outpatient Treatment of PD-related Peritonitis (Annex I.3B)	
F. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
G. Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

Certified correct by:**	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Nephrologist	(Printed name and signature) Please tick appropriate box ☐ Head, Peritoneal Dialysis Unit OR ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
PhilHealth Accreditation ☐☐☐☐ - ☐☐☐☐☐☐ - ☐☐	PhilHealth Accreditation ☐☐☐☐ - ☐☐☐☐☐☐ - ☐☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

MASTER COPY DC: Noah Date: 12/10/24

**for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.

Annex G.3C: Checklist of Requirements For Reimbursement – PD-related Ancillary Services

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 – PD-related Ancillary Services (Laboratory/Diagnostics Tests and Drugs/Medicines)

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

REQUIREMENTS	Status
A. Transmittal Form (Annex K)	
B. Accomplished Checklist of Requirements for Reimbursement (Annex G.3C)	
C. Properly accomplished Claim form (CF) 2	
D. Photocopy of PD passport (Annex D)	
E. Accomplished Checklist of Essential Health Services for PD-related Ancillary Services – Laboratory/Diagnostic Tests and Drugs/Medicines (Annex I.3C)	
F. Original or Certified true copy (CTC) of the Statement of Account (SOA)	
G. Z Satisfaction Questionnaire (Annex H)	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

Certified correct by:**	Certified correct by: (for Service Patients)
(Printed name and signature) Attending Nephrologist	(Printed name and signature) Please tick appropriate box ☐ Head, Peritoneal Dialysis Unit OR ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
PhilHealth Accreditation ☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation ☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

**for PRIVATE PATIENTS, the signature of the Attending Nephrologist is sufficient.

MASTER COPY DC: hospital Date: 12/20/24

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 Benefits package availed is for:

☐ Acute lymphoblastic leukemia
☐ Breast cancer
☐ Prostate cancer
☐ Kidney transplantation
☐ Post kidney transplantation services
☐ Cervical cancer
☐ Coronary artery bypass surgery
☐ Surgery for Tetralogy of Fallot
☐ Surgery for ventricular septal defect
☐ ZMORPH/Expanded ZMORPH
☐ Orthopedic implants
☐ Peritoneal dialysis
☐ 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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DC: Yes/No Date: 12/nov/14

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

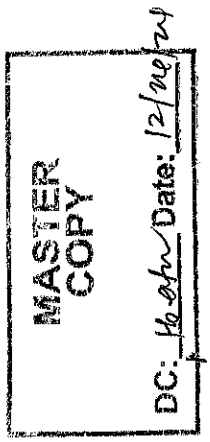
7. In your opinion, by how much has your HF expenses been lessened by availing of the Z benefit package?
☐ less than half
☐ by half
☐ more than half
☐ don't know

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 I.1A: Checklist of Essential Health Services Using CAPD - Adult

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)	DATE OF CONSULTATION (mm/dd/yyyy)
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	☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
Name of the Attending Nephrologist		

I. Peritoneal Dialysis Solutions Using CAPD		
A. Number of bags and glucose content using 2L bags (indicate the number of bags on the blank) _____ 1.5% _____ 2.5% or 2.3 % _____ 4.25%	B. Number of exchanges covered by PhilHealth per day (place a ✓ opposite appropriate answer) _____ 3 _____ 4	C. Calcium content (place a ✓ opposite appropriate answer) _____ Low _____ Regular

II. Supplies and Commodities — Place a (✓) opposite appropriate answer
A. PD Transfer set ☐ Transfer set given (2 per calendar year, every six months)
B. ☐ PD adapter
C. ☐ PD Clamp
D. ☐ Topical antiseptic spray

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

Annex I.1B: Checklist of Essential Health Services for Exit Site Infection and Peritonitis Prevention Care - Adult

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)		DATE OF CONSULTATION (mm/dd/yyyy)
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
Name of the Attending Nephrologist		

Place a (✓) opposite appropriate answer

Essential Health Services	
a. Laboratory, Diagnostic and Imaging	☐ CBC ☐ Creatinine ☐ Sodium ☐ Potassium ☐ Calcium ☐ Albumin ☐ Scout film of abdomen (as indicated) ☐ Exit site discharge gram stain (GS) and culture and sensitivity (CS) (as indicated)
b. Medicines, Supplies and Commodities	☐ Antimicrobials Specify: _____ ☐ Mupirocin or its equivalent Specify: _____ ☐ Nystatin (as indicated) ☐ Exit site dressing kit

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

MASTER COPY
DC: fb emp Date: 12/06/24

Annex I.2A: Checklist of Essential Health Services Using CAPD PD Bags - Pediatric

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)	DATE OF CONSULTATION (mm/dd/yyyy)
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
Name of the Attending Pediatric Nephrologist		

I. Peritoneal Dialysis Solutions Using CAPD		
A. Number of bags and glucose content using 2L bags (indicate the number of bags on the blank) _____ 1.5% _____ 2.5 % or 2.3 % _____ 4.25%	B. Number of exchanges covered by PhilHealth per day (place a (✓) opposite appropriate answer) _____ 4 _____ 5 _____ 6	C. Calcium content (place a ✓ opposite appropriate answer) _____ Low _____ Regular

II. Supplies and Commodities	Place a (✓) opposite appropriate answer
A. PD Transfer set ☐ Transfer set given (2 per calendar year, every six months) B. ☐ PD adapter C. ☐ PD Clamp D. ☐ PD drainage bag E. ☐ Topical antiseptic spray	

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

MASE... CO. DC: 12/20/24

Annex I.2B: Checklist of Essential Health Services Using APD PD Bags - Pediatric

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)		DATE OF CONSULTATION (mm/dd/yyyy)
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	☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
Name of the Attending Pediatric Nephrologist		

I. Peritoneal Dialysis Solutions Using APD		
A. Number of bags and glucose content using 5L bags (indicate the number of bags on the blank) _____ 1.5% _____ 2.5 % or 2.3 % _____ 4.25%	B. Number of exchanges covered by PhilHealth per day (place a (✓) opposite appropriate answer) _____ 1 _____ 2 _____ 3	C. Calcium content (place a ✓ opposite appropriate answer) _____ Low _____ Regular

II. Supplies and Commodities	Place a (✓) opposite appropriate answer
A. ☐ APD Cassette B. ☐ APD Drain bag	

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

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DC: Date: 12/09/24

Annex I.2C: Checklist of Essential Health Services for Exit Site Infection and Peritonitis Prevention Care - Pediatric

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)	DATE OF CONSULTATION (mm/dd/yyyy)
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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
Name of the Attending Pediatric Nephrologist		

Place a (✓) opposite appropriate answer

	Essential Health Services
a. Laboratory, Diagnostic and Imaging	☐ CBC ☐ Creatinine ☐ Sodium ☐ Potassium ☐ Calcium ☐ Albumin ☐ Scout film of abdomen (as indicated) ☐ Exit site discharge gram stain (GS) and culture and sensitivity (CS) (as indicated)
b. Medicines, Supplies and Commodities	☐ Antimicrobials Indicate: _____ ☐ Mupirocin or its equivalent ☐ Nystatin (as indicated) ☐ Exit site dressing kit

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

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DC: Master Date: 12/nov/24

Annex I.3A: Checklist of Essential Health Services for PD Catheter Insertion and Initiation for Adults and Pediatric Patients

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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Place a (✓) opposite appropriate answer

Essential Health Services	
a. Laboratory and Diagnostic Tests (as indicated)	☐ Complete Blood Count (CBC) ☐ Creatinine ☐ Sodium ☐ Potassium ☐ Calcium ☐ Albumin ☐ Phosphorous ☐ Protime ☐ Partial thromboplastin time ☐ Electrocardiogram (ECG) ☐ Chest X-Ray ☐ Scout film of abdomen
b. Procedure	☐ PD Catheter Insertion Date of procedure (mm/dd/yyyy): _____ ☐ PD Initiation Date of procedure (mm/dd/yyyy): _____
c. Medicines (as indicated)	☐ PD solutions (2L) or (5L) bags ☐ Calcium gluconate ☐ Sodium bicarbonate ☐ Amlodipine ☐ Non-calcium-based phosphate binders (e.g. sevelamer 800mg/tab) ☐ Angiotensin receptor blocker or ACE-inhibitor Indicate: _____ ☐ Ferrous sulfate

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Essential Health Services	
	□ Folic Acid □ Erythropoietin □ Enema □ Lactulose □ Mupirocin or its equivalent □ Potassium (IV) □ Calcium (IV)
d. Supplies and Commodities (as indicated)	□ Normal saline solution □ PD solution 2.0 liter per bag (1.5%, 2.3% or 2.5%, 4.25% dextrose or their equivalent) and 5 liters per bag for cycle Indicate: _____ □ PD Transfer Set □ PD Adapter □ PD Clamp □ PD Drain Bag □ Automated PD* for initiation (total of up to 40 exchanges of up to 1.5L/exchange or up to a maximum of 12 x 5L PD bags depending on baseline BUN, creatinine prior to CAPD training) including automated PD set with cassette 4-prong □ PD Catheter

*For accredited PD Z providers with PD cycler machines

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

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DC: Date: 12/09/24

Annex I.3B: Checklist of Essential Health Services for Outpatient Treatment of PD-related Peritonitis for Adults and Pediatric Patients

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Place a (✓) opposite appropriate answer

Essential Health Services	
a. Laboratory and Diagnostic Tests	☐ CBC ☐ Creatinine ☐ Sodium ☐ Potassium ☐ Calcium ☐ Albumin ☐ Scout film of abdomen ☐ Dialysate effluent cell count ☐ Dialysate effluent culture and sensitivity (CS)
b. Procedure/ Services	☐ Consultation Indicate the date (mm/dd/yyyy): _____
c. Medicine, Supplies and Commodities	☐ Antimicrobials (e.g. vancomycin 1g/vial, amikacin 250mg or 500mg/vial) Indicate: _____ ☐ Heparin 1,000IU/mL, 5 mL vial ☐ Mupirocin or its equivalent ☐ Nystatin (as indicated) ☐ Medical supplies Indicate: _____

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

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Annex I.3C: Checklist of Essential Health Services for Laboratory/Diagnostic Tests and Drugs/Medicines For PD Adults and Pediatric Patients

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Place a (✓) opposite appropriate answer

Essential Health Services	
a. Laboratory / Diagnostic Tests (as indicated)	Monthly Adult and pediatric patients ☐ CBC ☐ BUN ☐ Creatinine ☐ Potassium ☐ Calcium ☐ Phosphorus Applicable for pediatric patients ☐ Sodium ☐ Magnesium Quarterly Adult and pediatric patient ☐ Uric Acid ☐ Albumin Quarterly Adult ☐ Fasting blood sugar (FBS) or random blood sugar (RBS) Pediatric patients ☐ 25-OH vitamin D ☐ Intact parathyroid hormone (iPTH) ☐ Alkaline phosphatase ☐ Serum iron ☐ Total iron binding capacity (TIBC)

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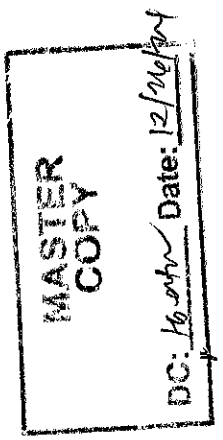
Essential Health Services	
	□ Ferritin Twice per year Adult □ HBsAg □ Anti-HCV Pediatric patients (every six (6) months) □ Peritoneal Equilibrium Test Adult (as necessary) □ HBA1c
b. Drugs / Medicines (as indicated)	Adult and Pediatric Patients □ Erythropoietin - stimulating agents (e.g. erythropoietin (epoetin) alpha, epoetin beta) Indicate: _____ □ Cholecalciferol 800 IU/cap □ Iron supplements oral 325mg/tab □ IV iron 20mg/ml 5ml amp □ Calcium-based phosphate binders 500mg/tab □ Non-calcium-based phosphate binders (e.g. sevelamer 800mg/tab) Indicate: _____ □ Mupirocin or its equivalent □ Topical antiseptic spray

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



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

Accreditation and Contracting Peritoneal Dialysis (PD) Z Benefits Providers

1. PhilHealth shall contract capable accredited health facilities to render the services of Z Benefits for PD for adult and pediatric patients

2. The accredited and contracted PD Z Benefit providers shall be capable of delivering all the mandatory services as well as the minimum standards of care for all PD patients enrolled under the Z Benefits as declared in its self-assessment.

3. An HF that intends to be accredited and contracted as a PD Z Benefits package provider shall submit the following documentary requirements:
   a. Provider Data Record (PDR)
   b. Performance Commitment (PC)
   c. Accreditation Fee: P 5,000
   d. Letter of Intent (LOI);
   e. Properly accomplished self-assessment tool (SAT); and
   f. Detailed co-payment proposal or a certification of zero-co-payment, as applicable.

4. The contract shall contain the terms and conditions agreed upon during the negotiation between PhilHealth and the HF that will render the services under the Z Benefits package for PD.

5. The accredited HF shall submit a copayment proposal that details the amenities and additional services or procedures not covered by the Z Benefits package for PD.

6. Co-payment shall not exceed the package rates 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.

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

8. 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.

9. Accredited PD Z providers with an existing contract for the Z Benefits package for PD shall update their co-payment proposal.

10. All other existing accrediting and contracting processes shall apply.

Annex K: Transmittal Form of Claims
For the PD Z Benefits

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2586 www.philhealth.gov.ph
PhilHealthOfficial X teamphilhealth

TRANSMITTAL FORM OF CLAIMS FOR THE PD 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: Z022A1
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
	Designation	Received by Local Health Insurance Office (LHIO)		
Printed Name and Signature	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

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Annex L: Home Visitation Questionnaire For PD Z Benefits Package

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

Control Number: _____

FIELD SURVEY TOOL FOR PD Z BENEFITS

READ BEFORE STARTING THE INTERVIEW:

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

Na-identify kayo bilang respondent sa pamamagitan ng pagpili ng computer sa mga pasyente na naka-avail na ng Z benefit sa mga contracted hospitals. Ayon sa talaan namin, kayo ay na-enroll ng *(state the hospital)* sa ilalim ng PD Z Benefits noong *(state month and year)*.

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

I. PATIENT INFORMATION

A. **Name of Patient (initials):** _____

B. **Permanent Address:** _____
_____

C. **Phone Number/s:**
1. _____
2. _____
3. _____

D. **Email address/es:**
1. _____
2. _____

E. **PhilHealth membership status:**
☐ Member ☐ Dependent

F. **Employment status:**
Currently working ☐ Yes ☐ No
If yes, nature of work:
_____
If no, who supports patient:
_____

G. **Age** (in years) : _____

H. **Birthdate:** _____
(mm/dd/yyyy)

I. **Sex:** ☐ Male ☐ Female

J. **Marital status of patient:**
☐ Single
☐ Legally married
☐ With partner
☐ Widow/ widower (encircle)

K. **Educational status of patient:**
☐ Elementary
☐ High school
☐ College
☐ Vocational
☐ Post Graduate
☐ Others: specify _____

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II. RESPONDENT INFORMATION (if respondent is not the patient)

A. **Name of Respondent:**
(Last name, first name, middle initial, extension)

_____

B. **Relationship to patient:**
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

C. **Age** (in years) : _____

D. **Sex:** ☐ Male ☐ Female

E. **Educational status of patient:**
- ☐ Elementary
- ☐ High school
- ☐ College
- ☐ Vocational
- ☐ Post Graduate
- ☐ Others: specify _____

III. INFORMATION ON CONTACT PERSON, PERSON TRAINED ON PD, AND CAREGIVER

A. **Name of contact person:**
(Sino ang pwede tawagan kung may kailangan pang impormasyon?)

_____

Relationship to patient:
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

Permanent Address of contact person:

_____

Contact Number/s of contact person:

_____

B. Were you (pertaining to the patient) trained to do the PD exchanges?
(Na-train po ba kayong mag-PD?)
☐ Oo ☐ Hindi

C. Name of the person trained on PD aside from the patient: (Bukod sa inyo, sino pa po ang na-train na mag-PD?)

_____

Relationship to patient:
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

Permanent address of the person trained on PD:

_____

Contact Number/s:

_____

D. **Who takes care of you?**
(Sino ang nag-aalaga sa inyo?)

Relationship to patient:
- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Guardian
- ☐ Others: specify: _____

E. Is the the person doing your PD exchange the same person who was trained by the PD facility's (PD Unit, NKTI or other PD facility) PD Nurse?
(Siya din po ba ng na-train sa PD)
☐ Oo ☐ Hindi

If NO, who trained the person doing your PD exchanges now?
(Kung HINDI, sino ang gumagawa ng PD sa inyo?)

_____

Educational status of the person doing your PD exchanges now:
- ☐ Elementary
- ☐ High school
- ☐ College
- ☐ Vocational
- ☐ Post Graduate
- ☐ Others: specify _____

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IV. OTHER INFORMATION ON PD OF THE PATIENT

A. Date of PD catheter insertion
(Kailan inilagay ang PD catheter?)
(mm/dd/yyyy) :_____

B. Date of PD initiation
(Kailan nagsimula ang PD?) (mm/yyyy):
_____
Name and address of HCI where PD was initiated
_____
_____

C. Number of PD exchanges/day
(Ilang beses isinasagawa ang PD sa isang araw):
☐ 3 exchanges/day
☐ 4 exchanges/day
☐ Others: _____
☐ Who does the PD of the patient?

D. Who does the PD of the patient?
(Sino ang gumagawa ng PD niyo?)
☐ Patient
☐ "Caregiver"
☐ Others:_____

E. How much PD solution is infused through the PD catheter per PD exchange?
(Gaano karaming PD solution ang ipinapasok sa tiyan?)
☐ 1 liter
☐ 2 liters
☐ Others: _____

F. How many PD exchanges did your doctor prescribe to you?
(Ilang PD exchanges ang kailangan niyong gawin base sa reseta sa inyo ng doctor?) _____

G. How many PD boxes are supplied by the contracted health care institution per two weeks?
(Ilang PD boxes ang binibigay sa inyo ng ospital o clinic kada dalawang linggo?)
_____bags kada dalawang linggo

H. If with excess PD bags/boxes, what does the patient do with them?
(Kung may sobrang PD bags/boxes, anong ginagawa ninyo sa mga ito?
_____

I. Approximate number of episodes of infection (peritonitis) since PD initiation?
(Ilang beses kayong nagka-infection mula ng magsimula kayong mag-PD?) _____

J. Approximate number of episodes of infection (peritonitis) since enrolment into the PD Z Benefits?
(Ilang beses kayong nagka-infection mula ng ma-enrol kayo sa PD Z Benefits?) _____

K. Daily activities

Maligo	☐May tulong	☐ Walang tulong
Maglinis ng bahay	☐Oo	☐Hindi
Maglaba	☐Oo	☐Hindi
Magluto	☐Oo	☐Hindi
Mamasyal (ex. mag-mall)	☐Oo	☐Hindi
Magtrabaho	☐Oo	☐Hindi
Mag-aral (if student)	☐Oo	☐Hindi
Bedridden (nakaratay)	☐Oo	☐Hindi

Others: (May iba pa ba kayong ginagawa bukod sa mga nabanggit gaya ng sports, gardening, exercise, etc. _____

V. INFORMATION ON PD TECHNIQUE

A. Kayo ba ay naturuan ng pamamaraan ng peritoneal dialysis (PD)?
☐ Oo ☐ Hindi

B. Kung naturuan, sino ang nagturo?
☐ Doctor
☐ Nurse
☐ Others: _____

C. Naghuhugas po ba kayo ng kamay bago mag-PD?
☐ Oo ☐ Hindi

Kung OO, ano ang ginagamit sa paghugas ng kamay?
☐ Tubig at sabon
☐ Alcohol
☐ Hand sanitizer

Kung OO, gaano kadalas maghugas ng kamay?
☐ Palagi
☐ Minsan

D. Nagsusuot po ng mask habang gumagawa ng PD?
☐ Oo ☐ Hindi

Kung OO, gaano kadalas magsuot ng mask habang gumagawa ng PD?
☐ Palagi
☐ Minsan

VI. ADAPTATION SKILLS

Ano ang pakiramdam mo sa iyong pagda-dialysis? (Markahan ng X)




☐ Ako ay umaasang gagaling din

☐ Wala akong nararamdaman o pakialam

☐ May pagkakataon na ako'y nalulungkot o nade-depress

☐ Wala na akong pag-asang gumaling

VII. FUTURE PLAN FOR KIDNEY TRANSPLANTATION

1. May idea ba kayo kung ano ang kidney transplantation? ☐ Meron ☐ Wala
   (Kung "wala" proceed to VIII)
2. Kung "meron" and sagot, may plano po ba kayo na magpa-kidney transplant? ☐ Meron ☐ Wala
3. Kung "meron" ang sagot sa no. 2, kalian ninyo balak magpa-kidney transplant? _____
4. Kung "wala" ang sagot sa no. 2, bakit wala kayong balak na magpa-kidney transplant?
   _____
   _____

VIII. SATISFACTION

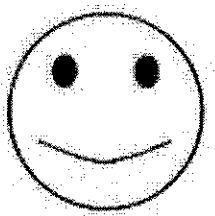
A. Aling ospital or pasilidad ang nag enroll sa inyo sa PD Z benefits?
   _____

B. Kayo ba ay nasiyahan sa serbisyong natanggap ninyo mula sa ospital o pasilidad na nagbigay ng Z benefits?
   ☐ Oo ☐ Hindi

C. Kung kayo ay nasiyahan, anu-ano ang inyong ikinasiya tungkol sa serbisyong natanggap ninyo?
   _____
   _____

D. Kung hindi kayo nasiyahan, anu-anong dahilan?
   _____
   _____

E. Kung kayo ay nasiyahan sa serbisyong PD na inyong natanggap, paano ninyo isasalarawan ang inyong kasiyahan? (Markahan ng X)


☐ Lubos na masaya ☐ Masaya ☐ Di masaya

IX. PHILHEALTH BENEFIT

A. May binayaran ba kayo mula ng kayo ay na-enroll sa PD Z benefits? ☐ Meron ☐ Wala

B. Kung "meron" anu-ano ang mga binayaran ninyo at magkano?

Item	Amount

C. May binayaran ba kayong professional fee ng doctor? ☐ Meron ☐ Wala

D. Kung "meron" magkano po ang binabayaran professional fee ng doctor kada check-up? _____

E. Naitago po ba ninyo ang mga resibo ng mga binayaran? ☐ Oo ☐ Hindi

F. Kung "oo," pwede po ba naming makita ang mga resibo at mailista o makuhanan ng picture ang mga ito?
☐ Oo ☐ Hindi

Item	Amount indicated in receipt

X. MODE OF TRANSPORTATION

A. Ano ang gamit ninyong sasakyan papunta ng ospital o pasilidad ng PD tuwing check-up:
☐ Public, specify _____
☐ Private, specify: _____
☐ Sariling sasakyan
☐ Nirerentahan
☐ Ambulance
☐ Barangay/other government vehicles
☐ Naglalakad lang

B. Ano ang gamit ninyong sasakyan papunta ng ospital o pasilidad ng PD para mag -pick-up ng PD bags:
☐ Public , specify _____
☐ Private, specify: _____
☐ Sariling sasakyan
☐ Nirerentahan
☐ Ambulance
☐ Barangay/other government vehicles
☐ Naglalakad lang

XI. PATIENT COMMENTS

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

_____

_____

B. May nais ba kayong imungkahi para mapabuti pa ang serbisyo ng ospital o pasilidad ng PD?

_____

_____

XII. SURVEYOR OBSERVATIONS

A. General appearance of the patient

Ambulatory ☐ Oo ☐ Hindi
(Nakakatayo / Nakakapaglakad)

Naka-wheelchair ☐ Oo ☐ Hindi
Bedridden ☐ Oo ☐ Hindi
Inaantok ☐ Oo ☐ Hindi
Malinis sa katawan ☐ Oo ☐ Hindi
Matamlay ☐ Oo ☐ Hindi
Others: _____

B. Is patient doing PD exchange at time of home visit? ☐ Yes ☐ No

C. Is there a specific area in the house where the patient performs the PD exchanges?
☐ Yes ☐ No ☐ NA ☐ Don't know

D. If yes, is the area free from clutter, dirt and dust?
☐ Yes ☐ No

E. Is there source of water for handwashing?
☐ Yes ☐ No

F. Is there adequate lighting? ☐ Yes ☐ No

G. Is there area for storage of PD solutions?
☐ Yes ☐ No

H. If yes, is it free from:
bug infestations ☐ Yes ☐ No
water damage/dampness ☐ Yes ☐ No

I. Number of unused PD bag/s: _____

J. Number of used PD bag/s: _____

K. Number of Andy disk/s: _____

Name of interviewer: _____ Designation: _____
Name of documenter: _____ Designation: _____
Date of interview (mm/dd/yyyy): _____ Time of interview: _____