Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PHILHEALTH CIRCULAR
No. 2025 - 0004

TO : **ALL CONTRACTED HEALTH FACILITIES FOR THE Z BENEFITS FOR OPEN HEART SURGERIES, AND ALL OTHERS CONCERNED**

SUBJECT : **Z Benefits Package for Open Heart Surgeries**

I. RATIONALE

Cardiovascular diseases (CVDs) are the leading causes of death globally. An estimated 17.9 million people died from CVDs in 2019, representing 32% of all global deaths[1]. In the Philippines, based on the 2023 data from the Philippine Statistics Authority (PSA), heart disease is a leading cause of death among Filipinos, accounting for 19.1% of all fatalities[2]. In children, congenital heart diseases (CHDs) affect nearly 1% or about 40,000 births per year[3]. Among the types of CHDs, ventricular septal defect (VSD) affects 2 to 6 of every 1000 live births (0.25%) which accounts for more than 20% of all CHDs while tetralogy of Fallot (TOF) remains the most common type of cyanotic CHD affecting 0.34 per 1000 live births worldwide. In the Philippines, based on the 2016 data, the incidence of VSD accounts for 0.34% while TOF cases accounted for 0.24%[4].

Republic Act (RA) No. 7875, as amended by R.A. Nos. 9241 and 10606 (National Health Insurance Act of 2013), mandates PhilHealth to provide responsive benefits and improve its benefits package to meet the needs of its members, which developed the Z Benefits package for open heart surgeries in 2013 covering surgeries and cardiac rehabilitation therapy. With the enactment of RA No. 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. 2972 s. 2024, the PhilHealth Board of Directors approved the coverage for open heart surgeries covering coronary artery bypass graft (CABG), VSD and TOF.

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[1]https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)
[2]Philippine Statistics Authority (2024)
[3]https://www.heart.org/en/health-topics/congenital-heart-defects/about-congenital-heart-defects
[4]Philippine Pediatric Society (2023)

II. OBJECTIVES

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

III. SCOPE

This PhilHealth Circular shall apply to all contracted health facilities (HFs) and all others involved in the implementation of the Z Benefits package for open heart surgeries particularly CABG, VSD, and TOF.

IV. DEFINITION OF TERMS

A. Basic or Ward Accommodation – provision of regular meal, bed in shared room, fan ventilation, shared toilet and bath. No other fees or expenses shall be charged to patients admitted in basic accommodation. Special beds, as defined in this PhilHealth Circular shall be treated as basic or ward accommodation under the Z Benefits.

B. Case-based Provider Payment Mechanism – 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.

C. Congenital Heart Disease (CHD)[5] – heart malformations or defects in the heart that occur from birth due to problems or factors that have affected heart development in the first 8-12 weeks intra-utero soon after conception. Common types of CHD include ventricular septal defect (VSD) and Tetralogy of Fallot (TOF).

D. Contracted Health Facility – a PhilHealth–accredited health facility that enters into a contract with PhilHealth to provide the provision of essential health services for patients enrolled for the Z Benefits package.

E. Copayment[6] – a predetermined amount agreed upon by the contracted health facility (HF) and PhilHealth that is chargeable to patients to cover the share for amenities, choice of physician, specialist fees for private patients, or any additional or upgraded services during the episode of care before service access to manage moral hazards and adverse incentives. Copayment is an example of an out-of-pocket payment or cost-sharing mechanism intended to share the cost of healthcare between the insured and the insurer.

F. Coronary Artery Bypass Graft (CABG) – a surgical procedure that treats coronary artery disease (CAD) by improving blood flow to the heart.

1. **Standard Risk** – patients requiring CABG surgery with a Euroscore of less than 5%.

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[5] https://www.heart.org/en/health-topics/congenital-heart-defects/about-congenital-heart-defects

[6] PC No. 2021-0022. The Guiding Principles of the Z Benefits (Revision 1)

2. **Expanded Risk** – patients requiring CABG surgery with Euroscore of less than 5% but have additional comorbidity of high risk for postoperative acute renal injury which may require renal replacement therapy or those with moderate risk for postoperative pulmonary complications.

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

H. **Essential Health Services** – 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, monitoring procedures, and general supportive care.

I. **Lost to Follow-up** – a patient who has not come back as advised for the next consultation or visit, whichever is applicable. In the context of open heart surgeries, this refers to a patient who has not come back as advised for the immediate next cardiac rehabilitation treatment visit or within thirty (30) days from the scheduled patient visit. As such, visiting the health facility for cardiac rehabilitation services more than 30 days from the advised scheduled treatment renders the patient lost to follow-up.

J. **Member Empowerment (ME) Form** – a document showing that the patient is fully informed of their Z Benefit package, treatment options, treatment schedule, roles and responsibilities, and follow-up visits. 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**[7] – an approach to patient care involving team members from different professional backgrounds or work disciplines, with each member providing specific services while working collaboratively together to provide the best care to the patient.

L. **Postoperative Complications** - adverse conditions or medical issues that may arise within thirty (30) days after a surgical procedure.

M. **Pre-authorization** – approval process of PhilHealth in which the contracted HF determines whether an individual is qualified to avail of the benefits package based on the minimum selection criteria under the Z Benefits.

N. **Special Bed**[8] – an accommodation with additional fixtures and amenities that are essential to the provision of specialty care of patients, which includes, but are not limited to, critical care units, intensive care units, and isolation rooms.

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[7]Ibid.

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

V. POLICY STATEMENTS

A. Benefits Availment

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

2. All patients who meet the clinical criteria shall be eligible to avail of the Z Benefits package for open heart surgeries. The selection criteria are detailed in the Pre-authorization Checklist and Request Forms (Annex A.1. – A.3.), which shall serve as the basis for PhilHealth's approval. The approved pre-authorization shall be valid for a period of one hundred eighty (180) calendar days from the date of approval of the request.

3. PhilHealth shall contract capable accredited health facilities (Annex B: Supplementary Rules in Accrediting and Contracting Health Facilities) to provide the essential health services (Annex C: List of Essential Health Services) for the Z Benefits package for open heart surgeries.

4. The designated liaison of the contracted HF shall submit the properly accomplished original copy of the Pre-authorization Checklist and Request Form and Annex D: Member Empowerment (ME) Form, to the Local Health Insurance Office (LHIO) or the office of the Head of the PhilHealth Benefits Administration Section (BAS) with jurisdiction over the contracted HFs. These documents may also be scanned and emailed to the respective PROs for approval.

5. The benefits package for open heart surgeries cover the essential health services for surgical procedures for open heart and cardiac rehabilitation services.

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

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

8. The contracted HFs shall not charge copayment for essential health services and postoperative complications for patients admitted in basic or ward accommodation or if admitted in special beds.

9. The contracted HF may charge copayment or out-of-pocket (OOP) payment for services that are not included in the list of essential health services, choice of physician, specialist fees for private patients, 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 the contracted HF during the discussion of the ME Form for services beyond the scope of essential health services.

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

B. Responsibilities of the Contracted Health Facilities

1. The contracted HFs shall adhere to the selection criteria outlined in the pre-authorization checklist and request form when determining patients' eligibility to avail of this benefits package.

2. The contracted HFs shall inform all patients needing open heart surgeries (CABG, TOF, VSD) on the Z Benefits package, if qualified, patients shall be enrolled based on set rules specified in this policy.

3. The Multidisciplinary-interdisciplinary team (MDT) shall evaluate patients for open heart surgeries before enrolling patients under the Z Benefits. The MDT shall be composed of the following:

   a. Coronary Artery Bypass Graft (CABG) - Standard Risk
      a.1. Thoracic and Cardiovascular Surgeon (TCVS)
      a.2. Attending Cardiologist
      a.3. Cardiac Anesthesiologist
      a.4. Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
      a.5. Intensivist

   b. Coronary Artery Bypass Graft (CABG) - Expanded Risk
      b.1. TCVS
      b.2. Attending Cardiologist
      b.3. Cardiac Anesthesiologist
      b.4. Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
      b.5. Intensivist
      b.6. Pulmonologist
      b.7. Nephrologist
      b.8 Endocrinologist

   c. Ventricular Septal Defect (VSD) and Tetralogy of Fallot (TOF) or VSD with Severe Pulmonary Stenosis
      c.1. Pediatric TCVS
      c.2. Pediatric Cardiologist
      c.3. Pediatric Anesthesiologist
      c.4. Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
      c.5. Pediatric Intensivist

d. Ventricular Septal Defect (VSD) with Associated Special Conditions
   d.1. Pediatric TCVS
   d.2. Pediatric Cardiologist
   d.3. Pediatric Anesthesiologist
   d.4. Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
   d.5. Pediatric Intensivist
   d.6. Infectious Disease Specialist
   d.7. Neurologist
   d.8. Pulmonologist
   d.9. Nephrologist

4. The contracted HF shall manage any postoperative complications of open heart surgeries such as infections, bleeding, blood clots or side effects from medications.

5. 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.

6. The contracted HFs shall appoint at least one (1) Z Benefits Coordinator, whose responsibilities are outlined in PhilHealth Circular (PC) No. 2021-0022 "The Guiding Principles of the Z Benefits (Revision 1)," provided that, each Z Benefits Coordinator shall be permitted to manage a maximum of three (3) Z Benefits packages.

7. The contracted HFs shall maintain either digital or physical copies of all medical records for monitoring and post-audit purposes by PhilHealth.

8. As stipulated in the RA No. 11223 (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 government HFs.

C. Lost to Follow-up

1. The contracted HFs shall exhaust all efforts to contact, navigate, or obtain information about the whereabouts or situation of their patients within thirty (30) days after the scheduled cardiac rehabilitation treatment visit.

2. Patients who have not been declared lost to follow-up and return within thirty (30) days after their advised next cardiac rehabilitation session may continue the remaining rehabilitation sessions upon reassessment and referral by the attending cardiologist. The cardiac rehabilitation services shall be covered under this policy.

   If a patient returns more than thirty (30) days after the scheduled cardiac rehabilitation session, they will no longer be eligible to continue availing of the said Z Benefits for the particular episode of care.

3. In case of patients who are declared lost to follow-up or when the patient expires, the contracted HFs shall file claims based on the applicable scenarios:

   a. The contracted HF shall submit to PhilHealth an original copy of the 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 contracted HF shall submit a photocopy of the death certificate or a notarized sworn declaration issued by the authorized government agencies as an attachment to the claims. The contracted HF shall submit their claims within sixty (60) days from the receipt of the death certificate or notarized sworn declaration issued by authorized government agencies[9].

4. The claims for cardiac rehabilitation services of patients who expired or declared lost to follow-up shall be paid on a prorated basis.

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

1. The general package code for the Z Benefits Package for Open Heart Surgeries are as follows:

Package Code	Description
Z030	Z Benefits Package for Coronary Artery Bypass Graft Surgery
Z031	Z Benefits Package for the Closure of Ventricular Septal Defect
Z032	Z Benefits Package for the Total Correction of Tetralogy of Fallot
Z033	Post-Cardiac Surgery Services (CABG, VSD and TOF)

Table 1: Package Code of the Z Benefits Package for Open Heart Surgeries

2. Z Benefits Package for Coronary Artery Bypass Graft (CABG) Surgery

Package Code	Services	Package Rate (PHP)	Filing Schedule
Z030A	Coronary Artery Bypass Graft Surgery - Standard Risk	660,000	Within 60 days after discharge from the surgery

[9]PC No. 2021-0022. The Guiding Principles of the Z Benefits (Revision 1)

Package Code	Services	Package Rate (PHP)	Filing Schedule
Z030B	Coronary Artery Bypass Graft Surgery - Expanded Risk	960,000	Within 60 days after discharge from the surgery

Table 2: Package Code, Services, Package Rate and Filing Schedule of Z Benefits Package for CABG Surgery

3. Z Benefits Package for the Closure of Ventricular Septal Defect

Package Code	Services	Package Rate (PHP)	Filing Schedule
Z031A	Closure of Ventricular Septal Defect with or without Associated Special Conditions	498,000	Within 60 days after discharge from the surgery
Z031B	Closure of VSD with Severe Pulmonary Stenosis	614,000	Within 60 days after discharge from the surgery

Table 3: Package Code, Services, Package Rate and Filing Schedule of Z Benefits Package for the Closure of VSD

4. Z Benefits Package for the Total Correction of Tetralogy of Fallot

Package Code	Services	Package Rate (PHP)	Filing Schedule
Z032A	Total Correction of Tetralogy of Fallot	614,000	Within 60 days after discharge from the surgery

Table 4: Package Code, Services, Package Rate and Filing Schedule of Z Benefits Package for the Total Correction of TOF

5. Post-Cardiac Surgery Services

Package Code	Services	Package Rate (PHP)	Filing Schedule
Z033A1	Cardiac Rehabilitation for post-CABG surgery	54,000 (six sessions)	Within 60 days after the 6th rehabilitation session
Z033A2	Ancillary Services for post-CABG surgery: Laboratory/ Diagnostic Tests,	12,140	Within 60 days after the date of the last availment of the

Package Code	Services	Package Rate (PHP)	Filing Schedule
	Drugs/ Medicines		service/services
Z033B	Cardiac Rehabilitation Services for post-VSD or TOF surgery	6,500 (four sessions)	Within 60 days after the 4th rehabilitation session

Table 5: Package Code, Services, Package Rate and Filing Schedule of Post-Cardiac Surgery Services

E. Claims Filing and Reimbursement

1. The contracted HF shall provide the prescribed essential health services to patients covered by this benefits package.

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

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

4. The required signatories shall affix their signatures to attest that the services were provided to patients.

5. If the patient expires, the contracted HF may file their claim for reimbursement based on the number of cardiac rehabilitation sessions at a prorated basis.

6. For patients who are declared lost to follow-up, the contracted HF must have rendered the following minimum number of cardiac rehabilitation services to be eligible file a claim at a prorated basis:

   a. Four (4) cardiac rehabilitation services for post-CABG surgery patients
   b. Three (3) cardiac rehabilitation sessions for VSD and TOF patients.

7. The contracted HFs shall properly indicate the OOP and/or copayment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption of Benefits" and in the Statement of Account (SOA).

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

9. Contracted HFs shall follow all relevant laws, such as RA No. 9994 or the "Expanded Senior Citizens Act of 2010" and RA No. 10754 or the "Act Expanding the Benefits and Privileges of Persons with Disability (PWD)," including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on DOH-DSWD-PCSO-PHIC Joint Administrative Order No. 2020-0001 [Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019"].

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

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

11. The contracted HFs shall follow the documentary requirements for filing claims, as listed in the Checklist of Requirements for Reimbursement (Annex F), including Transmittal Form (Annex G), which shall be attached per claim or per batch of claims.

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

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

F. Claims Payment and Evaluation

1. PhilHealth shall reimburse the contracted HF that renders the essential health services prescribed to patients under this benefit package. Services provided shall be properly documented in the Checklist of Essential Health Services (Annex H).

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

2. PhilHealth shall pay the contracted HFs based on the predetermined package rates using a case-based payment. For incomplete cardiac rehabilitation services, payment shall be made on a prorated basis as stated in Section V.E.5 and 6 of this policy.

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

4. Reimbursement of ancillary services for post-CABG surgery (drugs or medicines, laboratory, and diagnostic tests) shall be based on the actual amount as reflected in the SOA or its equivalent and shall not exceed the amount indicated in table 5.

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

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

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

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

8. 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.

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

10. Claims filed by the contracted HF shall be denied based on the following instances:

    a. If a required essential health service was not provided by the contracted HF;
    b. Late filing;

c. Inconsistency of data and information contained in the claims application.

G. Monitoring

1. PhilHealth shall enforce current policies and guidelines on monitoring the performance of contracted HFs in implementing the Z Benefits Package for Open Heart Surgeries 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 Open Heart Surgeries, especially documenting adverse provider behaviors resulting in cost-push inflation, such as unwarranted increases in hospital charges.

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

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

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

H. Policy Review

PhilHealth shall conduct a regular policy review of the Z Benefits package in consultation and collaboration with relevant stakeholders, experts, and technical staff representatives from the Corporation. This PhilHealth Circular shall be enhanced as necessary based on the results of the policy review.

I. Marketing and Promotion

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

To further widen the reach to the general public, most especially to beneficiaries, PhilHealth likewise encourages contracted health facilities to

advertise the Z Benefits packages through different communication channels, including but not limited to respective remote or online platforms, provided that these are in accordance with the policies of each benefits package and the social marketing and communication plan of PhilHealth.

J. Annexes (To be posted in the PhilHealth website)

Annex A: Pre-authorization Checklist and Request Form

Annex A.1: Pre-authorization Checklist and Request for Coronary Artery Bypass Graft (CABG) - Standard Risk and Expanded Risk

Annex A.2: Pre-authorization Checklist and Request for Closure of Ventricular Septal Defect with or without Associated Special Conditions

Annex A.3: Pre-authorization Checklist and Request for Tetralogy of Fallot (TOF) or Closure of VSD with Severe Pulmonary Stenosis

Annex B: Supplementary Rules in Accrediting and Contracting Health Facilities

Annex C: List of Essential Health Services for the Z Benefits Package for Open Heart Surgeries

Annex C.1: List of Essential Health Services for Coronary Artery Bypass Graft (CABG)

Annex C.2: List of Essential Health Services for Closure of Ventricular Septal Defect (VSD) with or without Associated Special Conditions

Annex C.3: List of Essential Health Services for Tetralogy of Fallot (TOF) or Closure of VSD with Severe Pulmonary Stenosis

Annex D: Member Empowerment (ME) Form

Annex E: Z Satisfaction Questionnaire

Annex F: Checklist of Requirements for Reimbursement

Annex F.1: Checklist of Requirements for Reimbursement for Open Heart Surgery

Annex F.2: Checklist of Requirements for Reimbursement for Post-Cardiac Surgery Services

Annex G: Transmittal Form

Annex H: Checklist of Essential Health Services

Annex H.1: Checklist of Essential Health Services for Coronary Artery Bypass Graft (CABG) Surgery

Annex H.2: Checklist of Essential Health Services for Closure of Ventricular Septal Defect (VSD) with or without Associated Special Conditions

Annex H.3: Checklist of Essential Health Services for Tetralogy of Fallot (TOF) or Closure of VSD with Severe Pulmonary Stenosis

Annex H.4: Checklist of Essential Health Services for Post-Cardiac Surgery Services

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of RA No. 7875, as amended by RA Nos. 9241 and 10606 (National Health Insurance Act of 2013), RA No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, including the PhilHealth Rules on Administrative Cases (PROAC).

VII. TRANSITORY CLAUSE

A. Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to contracted health facilities 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 contracted HFs 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. This policy shall apply to all procedures with approved pre-authorization starting March 1, 2025. Contracted HFs may submit a new pre-authorization request to the PRO for patients whose pre-authorization was approved 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. 0002 s. 2013 "Z Benefit Package Rates for Coronary Artery Bypass Graft Surgery, Surgery for Tetralogy of Fallot, Surgery for Ventricular Septal Defect and Cervical Cancer" and PC No. 2021-0022 "The Guiding Principles of the Z Benefits (Revision 1)".

VIII. 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.

IX. REPEALING CLAUSE

This PhilHealth Circular amends specific provisions on PC No. 0002 s. 2013 (Z Benefit Package Rates for Coronary Artery Bypass Graft Surgery, Surgery for Tetralogy of Fallot, Surgery for Ventricular Septal Defect and Cervical Cancer) and PC No. 2021-0022 [The Guiding Principles of the Z Benefits (Revision 1)].

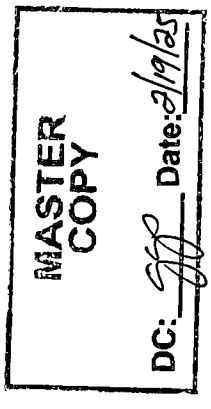
All other PhilHealth Circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on March 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.

EDWIN M. MERCADO, MD, MHA, MMSc
Acting President and CEO

Date signed: 2/18/2025



Annex A.1: Pre-authorization Checklist and Request for Coronary Artery Bypass Graft (CABG) - Standard Risk and Expanded Risk

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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(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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Place a check mark (✓)

QUALIFICATIONS	Yes
At least 19 years of age	

ATTESTED BY ATTENDING CARDIOLOGIST or CARDIOVASCULAR SURGEON

Place a check mark (✓)

CABG Risk Type	
☐ Standard risk	☐ Expanded risk

Place a check mark (✓)

QUALIFICATIONS	Yes
1. Stable coronary artery disease requiring ELECTIVE ISOLATED CABG with indication based on coronary anatomy, symptom severity, left ventricular function, and/or viability tests; non-invasive testing completed and discussed with patient	
2. Check current medical status: a. NOT in severe decompensated heart failure by New York Functional Classification (NYFC IV)	

MASTER COPY Date: 2/19/25 DC:

QUALIFICATIONS	Yes
b. NOT with severe angina by Canadian Cardiovascular Society (CCS Class IV)	
c. NO other cardiac/vascular procedures/interventions planned to be done with coronary artery bypass graft surgery during this admission	
d. NO history of dialysis and NO current requirement of dialysis	
3. Based on past history: a. NO previous thoracic/cardiac surgery through median sternotomy	
b. NO previous transcutaneous cardiac intervention within 30 days before contemplated schedule of coronary artery bypass graft surgery	
4. ONLINE EUROSCORE II and Society of Thoracic Surgeons (STS) scoring predictive of low mortality risk (< 5%)	

DIAGNOSTICS*	Yes	Date done (mm/dd/yyyy)
1. Coronary Angiography: coronary anatomy amenable for CABG and consistent with Class I and IIa indications for CABG surgery and discussed with patient		
2. Current status of myocardial viability consistent with benefit from CABG and discussed with patient		

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

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

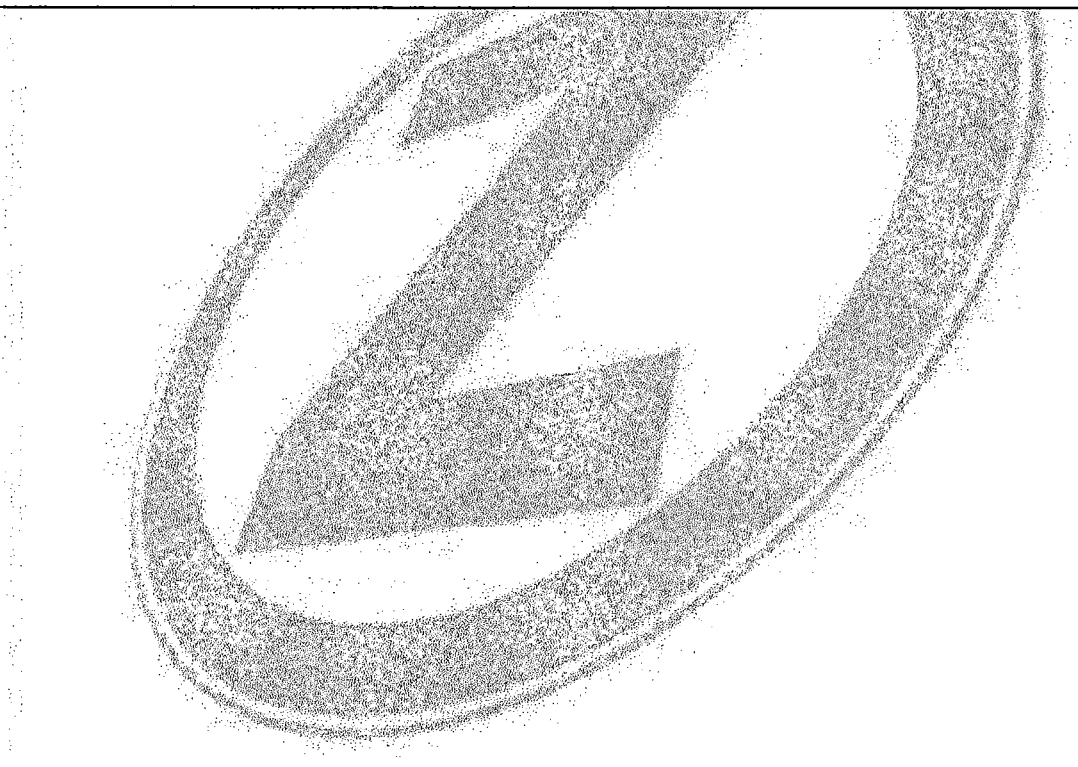
MASTER COPY
DC: Date: 2/19/25

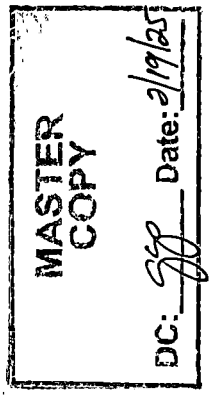
Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

Note:

Once approved, the contracted HF shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the LHIO or PRO when filing the initial claims.

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





PRE-AUTHORIZATION REQUEST
Coronary Artery Bypass Graft (CABG) - Standard Risk and Expanded Risk

DATE OF REQUEST (mm/dd/yyyy):

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

_____ in _____
(Patient's last, first, suffix, middle name) (Name of HF)
under the terms and conditions as agreed for availment of the Z Benefit Package.

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

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

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

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY
DC: _____ Date: 2/19/25

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

Annex A.2: Pre-authorization Checklist and Request for Closure of Ventricular Septal Defect With or Without Associated Special Conditions

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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

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

Place a check mark (✓)

QUALIFICATIONS	**Yes**
Age up to 18 years and 364 days (Check if applicable)	
a. Age 0 to less than 6 months approved by EXPERT PANEL	
b. Age 6 months to 9 and 364 days	
c. Age 10 years old up to 18 and 364 days and approved by EXPERT PANEL	

MASTER COPY Date: 2/19/25 DC:

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Ventricular Septal Defect (VSD) Closure

Place a check mark (✓)

DIAGNOSTICS[1]	**Yes**	**Date done (mm/dd/yy)**
Based on 2D Echocardiogram[2]: 1. Confirmed ventricular septal defect perimembranous, subaortic, or subpulmonic, or inlet type		

DIAGNOSTICS[1]	Yes	Date done (mm/dd/yy)
2. NO other associated congenital heart disease (CHD): such as atrioventricular septal defect, coarctation of the aorta, aortopulmonary window, or moderate to severe aortic insufficiency needing replacement		
3. No unstable congenital anomalies		
4. Pulmonary artery maximum systolic pressure gradient <55 mmHg or pulmonary valve annulus with a Z score of -1 to +1		
5. Pulmonary arterial pressure (PAP) normal, mild to moderate or less than 2/3 the systolic blood pressure, with hemodynamic studies, if applicable		

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

☐ **Ventricular Septal Defect (VSD) Closure with Associated Special Conditions**

Place a check mark (✓)

INDICATORS[1]	Yes	Date done (mm/dd/yy)
1. Based on 2D Echocardiogram[2]: a. Confirmed ventricular septal defect perimembranous, subaortic, subpulmonic, or inlet type		
b. NO other associated congenital heart disease (CHD): such as atrioventricular septal defect, coarctation of the aorta, aortopulmonary window, or moderate to severe aortic insufficiency needing replacement		
2. Any of the following may be allowed		
a. Combined with another shunt such as patent ductus arteriosus or atrial septal defect		
b. Moderate aortic insufficiency not warranting replacement		
c. Moderate Aortic stenosis with subaortic membrane		
d. Check any one (1) if applicable d.1. Pulmonary or Artery Pressure > 2/3 of systemic pressure but with reactive pulmonary bed by ECHO documented by cardiac catheterization		
d.2. if moderate to severe with borderline Pulmonary Vascular Resistance on cardiac catheterization approved by EXPERT PANEL		
e. Down's Syndrome with stable co morbidities		

MASTER COPY Date: 2/19/25 DC:

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

HEALTH 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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

Note:

Once approved, the contracted HF shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the LHIO or PRO when filing the initial claims.

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

MASTER COPY
DC: ___ Date: 2/19/25

PRE-AUTHORIZATION REQUEST
Closure of Ventricular Septal Defect With or Without Associated Special Conditions

DATE OF REQUEST (mm/dd/yyyy)

This is to request approval for provision of services under the Z benefit package for _____ in _____
(Patient's last, first, suffix, middle name) (Name of HF)
under the terms and conditions as agreed for availment of the Z Benefit Package.

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

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

Conforme by:
(Printed name and signature) Patient

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY
Date: 2/19/25
DC:

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

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

Annex A.3: Pre-authorization Checklist and Request for Tetralogy of Fallot (TOF) or Closure of VSD with Severe Pulmonary Stenosis

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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

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

Place a check mark (✓)

QUALIFICATIONS	**Yes**
Age up to 18 years and 364 days (Check if applicable)	
a. Age 0 to less than 6 months approved by EXPERT PANEL	
b. Age 6 months to 9 and 364 days	
c. Age 10 years old up to 18 and 364 days and approved by EXPERT PANEL	

MASTER COPY Date: 2/19/25 DC:

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

Check if applicable
☐ Total Correction of Tetralogy of Fallot
☐ Ventricular Septal Defect (VSD) Closure with Severe Pulmonary Stenosis

Place a check mark (✓)

QUALIFICATIONS	**Yes**
1. Check past history: a. No previous cardiac surgery or intervention such as BTS (Blalock Taussig Shunt)	

QUALIFICATIONS	Yes
b. No PDA Stenting or c. No residual VSD from previous open heart surgery for total correction	
2. Check physical examination: a. No hepatomegaly or b. No edema lower extremities	
3. No congenital chromosomal abnormalities or other congenital defects, except Trisomy 21 (Down's syndrome)	

Place a check mark (✓)

DIAGNOSTICS[1]	Yes	Date done (mm/dd/yyyy)
Based on the results of 2D Echocardiogram OR, if applicable, cardiac catheterization OR CT angiogram[2]: 1. Confirmed Tetralogy of Fallot OR Confirmed Ventricular Septal Defect and pulmonic stenosis, severe (This is similar to TOF morphology)[3] 2. No other associated congenital heart disease (CHD) that includes the following: i. absent pulmonic valve ii. associated Pulmonary valve atresia atrioventricular septal defect (AVSD) 3. Confluent and adequate pulmonary artery sizes OR acceptable pulmonary valve annulus 4. NO major aorto-pulmonary collateral arteries (MAPCA's)		
5. With Cardiac catheterization / CT angiogram for i. TOF > 10 years old ii. Age less than 6 months		

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

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

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

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

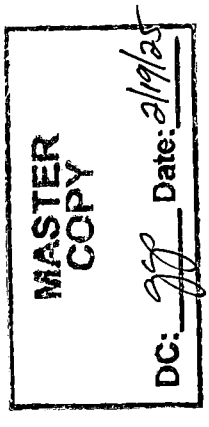
MASTER COPY Date: 2/19/25 DC:

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

Note:

Once approved, the contracted HF shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the LHIO or PRO when filing the initial claims.

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



PRE-AUTHORIZATION REQUEST
Tetralogy of Fallot or Closure of VSD with Severe Pulmonary Stenosis

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ in _____
(Patient's last, first, suffix, middle name) (Name of HF)
under the terms and conditions as agreed for availment of the Z Benefit Package.

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

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

Conforme by:

(Printed name and signature)
Patient

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

MASTER COPY
Date: 2/19/25

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

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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

Supplementary Rules in Accrediting and Contracting Health Facilities

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

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

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

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

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

6. Contracted HFs with an existing contract for the Z Benefits package for Open Heart Surgeries (Coronary Artery Bypass Graft, Ventricular Septal Defect and Tetralogy of Fallot) shall update their co-payment proposal.

7. For further guidance, please refer to PhilHealth Circular No. 2022-0012 "Contracting of a Health Facility as a Z Benefits Provider (Revision 1)" or its subsequent amendments.

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List of Essential Health Services for CABG

A. CABG Surgery – Standard Risk

Package Inclusion	Essential Health Services
1. Laboratory and Diagnostic Tests	CBC with platelet Blood typing Prothrombin time Activated partial thromboplastin time Electrolytes (Na, K, iCa, Mg, Cl) BUN Creatinine Albumin SGPT (as indicated) SGOT (as indicated) Urinalysis FBS Chest X-ray (PA lateral) 12 lead ECG Arterial blood gas (ABG) CBG monitoring 2D Echo with Doppler (as indicated)
2. Treatment	Incentive spirometry Blood products screening Nebulization (as indicated) Mechanical ventilator use
3. Drugs/ Medicines	Antiplatelet (aspirin, clopidogrel) Statin (Ex. rosuvastatin) Antimicrobial Prophylaxis As indicated/needed: Beta Blockers (Ex. metoprolol) ACE inhibitors, ARB (Ex. telmisartan) Sedation/pain (Ex. paracetamol IV, oral, diazepam, tramadol) Antimicrobials Gastrointestinal medications (Ex. omeprazole IV, oral) Pulmonary medications (Ex. salbutamol, budesonide nebule, salbutamol/

Package Inclusion	Essential Health Services
	ipratropium, acetylcysteine) Hemodynamic support (Ex. nitroglycerin amp, dobutamine) Electrolytes (Ex. KCl, Mg_2SO_4, Ca gluconate) Others: Calcium channel blockers (Ex. diltiazem) Digoxin (as indicated)
4. Procedures	CABG Surgery (inclusive of perfusion and anaesthesia)
5. Other Fees	Adult ward, SICU, CSR supplies

B. CABG Surgery – Expanded Risk

Package Inclusion	Essential Health Services
1. Laboratory and Diagnostic Tests	CBC with platelet Blood typing Prothrombin time Activated partial thromboplastin time Electrolytes (Na, K, iCa, Mg, Cl) BUN Creatinine Albumin SGPT (as indicated) SGOT (as indicated) Urinalysis FBS Chest X-ray (PA lateral) 12 lead ECG Arterial blood gas (ABG) CBG monitoring 2D Echo with Doppler (as indicated) Arterial duplex scan Chest CT scan (optional)
2. Treatment	Incentive spirometry Blood products screening Mechanical ventilator use As indicated/needed: Nebulization Intra-aortic balloon pump Renal Replacement Therapy (Maximum 5 sessions of hemodialysis) * (as indicated) Temporary pacemaker

Package Inclusion	Essential Health Services
3. Drugs/ Medicines	Antiplatelet (Aspirin, clopidogrel) Statin (Ex. rosuvastatin) Antimicrobial Prophylaxis As indicated/needed: Beta-blockers (Ex. metoprolol) ACE inhibitors, ARB (Ex. telmisartan) Sedation/pain (Ex. paracetamol IV, oral, diazepam, tramadol) Antimicrobial (Ex. amikacin) Gastrointestinal medications (Ex. omeprazole IV, oral) Pulmonary medications (Ex. salbutamol, budesonide nebule, salbutamol/ ipratropium, acetylcysteine) Hemodynamic support (Ex. nitroglycerin amp, dobutamine, norepinephrine, vasopressin) Electrolytes (Ex. KCl, Mg_2SO_4, Ca gluconate) Others: Calcium channel blockers (Ex. diltiazem) Digoxin (as indicated) Heparin (enoxaparin, UFH)
4. Procedures	CABG Surgery (inclusive of perfusion and anaesthesia Use of Catheter Laboratory (for IABP insertion) (as indicated)
5. Other Fees	Adult ward, SICU, CSR supplies

*Hemodialysis is included in the benefits package and shall not be filed separately

C. Post-Cardiac Surgery Services (Standard and Expanded Risk)

Package Inclusion	Essential Health Services
A. Cardiac Rehabilitation Services	
1. Rehabilitation Services	Physical Activity Counseling Exercise Training Nutritional Counseling Weight Management Blood Pressure Management Lipid Management Diabetes Management Smoking Cessation Psychosocial Management

Package Inclusion	Essential Health Services
2. Supplies and Use of Equipments	Heart Strengthening Equipment (Digital Treadmill, Arm Ergometer, Bicycle Ergometer, Dual Cycle Ergometer, Bicycle, Rowing Machine, Stair Climber, Blood Pressure Recording Machine, Wearable Devices, etc.
3. Administrative and Other Fees	Cardiac Rehab (OPD) Fee, Staff Time, Utilities
B. Ancillary Services	
1. Drugs/ Medicines	Antiplatelet (Ex. Aspirin) Statins (Ex. Atorvastatin) As indicated/needed: Beta Blockers (Ex. Metoprolol) Calcium Channel Blockers (Ex. Amlodipine) Nitrates (Ex. Isosorbide Dinitrate Sublingual, ISDN SL) Antiplatelet Agents (Ex. Clopidogrel Angiotensin Receptor Blockers (Ex. Losartan)
2. Laboratory/ Diagnostic Tests	Electrocardiogram (ECG) As indicated/needed: Cardiac Stress Test Complete Blood Count (CBC) Prothrombin Time Fasting Blood Sugar (FBS) Blood Urea Nitrogen (BUN) Serum Creatinine Electrolytes (Na, K, Mg, Ionized Ca)
3. Administrative and other fees	Staff time, utilities and referral fees to Cardiologist/ Other Specialists

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List of Essential Health Services for Closure of Ventricular Septal Defect (VSD) with or without Associated Special Conditions

A. Ventricular Septal Defect Closure

Package Inclusion	Essential Health Services
1. Laboratory/ Diagnostic Tests	CBC Blood typing Prothrombin time Activated partial thromboplastin time (APTT) Serum Electrolytes (Na, K, iCa, Mg) BUN Creatinine Albumin Chest X-ray (PA Lateral, portable) 12 lead ECG bedside Serum Lactate Arterial Blood Gas (ICU, complete panel, pulmonary) CBG monitoring 2D Echo with Doppler (Transthoracic) Transesophageal Echocardiogram
2. Drugs/ Medicines	Propranolol Furosemide IV, oral ACE inhibitor (Ex. captopril) Spironolactone Digoxin Nicardipine Sodium bicarbonate Sedation and pain: (paracetamol IV, oral, midazolam, propofol, fentanyl) Povidone iodine Antimicrobials: (vancomycin, amikacin, mupirocin) Omeprazole Pulmonary medications: (salbutamol nebule, budesonide nebule, acetylcysteine) Hydrocortisone

Package Inclusion	Essential Health Services
	Hemodynamic support: (nitroglycerin, dobutamine) IVF Electrolytes (Ex. KCl, Mg_2SO_4, Ca gluconate) Others: dextrose, normal saline solution (NSS), sterile water for injections (SWI)
3. Ancillary Services	Dietary (caloric requirement) Pulmonary Services: Incentive spirometry Mechanical ventilator use
4. Blood Bank Services	Antibody screening test-patient Hepatitis Screening (Anti-HCV, HBsAg) Cross matching HIV Screening Blood donor antibody screening test (per component) Storage and handling fees Drug assay for blood donor
5. Procedures	VSD Closure (Inclusive of perfusion (heart lung machine) Anaesthesia (machine) Anaesthetics (Ex. ketamine)
6. Administrative and Other Fees	Pedia Ward, SICU OR Supplies CSR Supplies

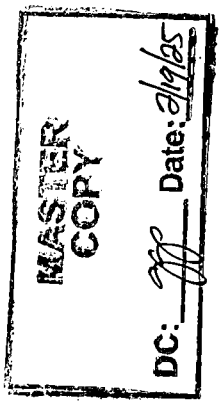
B. VSD with Associated Special Conditions

Package Inclusion	Essential Health Services
1. Laboratory/ Diagnostic Tests	CBC Blood typing Prothrombin time Activated partial thromboplastin time Serum Electrolytes (Na, K, iCa, Mg) BUN/ creatinine Albumin Chest X-ray (PA Lateral, portable) 12 lead ECG bedside Serum Lactate Arterial Blood Gas (ICU, complete panel, pulmonary) CBG monitoring 2D Echo with Doppler (Transthoracic)

Package Inclusion	Essential Health Services
	Transesophageal Echocardiogram
2. Drugs/ Medicines	Propranolol Furosemide IV, oral ACE inhibitor (Ex. captopril) Spironolactone Digoxin Nicardipine Sodium bicarbonate Sedation and pain: (paracetamol IV, oral, midazolam, propofol, fentanyl) Povidone iodine Antimicrobials: (vancomycin, amikacin, mupirocin) Omeprazole Pulmonary medications: (salbutamol neb, budesonide neb, acetylcysteine) Hydrocortisone Hemodynamic support: (nitroglycerin, dobutamine) IVF Electrolytes (Ex. KCl, Mg_2SO_4, Ca gluconate) Others: dextrose, normal saline solution (NSS), Sterile Water for Injection
3. Ancillary Services	Dietary (caloric requirement) Pulmonary Services: Incentive spirometry Mechanical ventilator use
4. Blood Bank Services	Antibody screening test-patient Hepatitis Screening (Anti-HCV, HBsAg) Cross matching HIV Screening Blood donor antibody screening test (per component) Storage and handling fees Drug assay for blood donor
5. Procedures	VSD Closure (Inclusive of perfusion (heart lung machine) Anaesthesia (machine) Anaesthetics (Ex. ketamine)
6. Administrative and Other Fees	Pedia Ward, SICU OR Supplies CSR Supplies

C. Cardiac Rehabilitation Services

Package Inclusion	Essential Health Services
1. Cardiac Rehabilitation	Daily assessment Pre rehabilitation orientation Post rehabilitation discharge instructions
2. Admin and Other Fees	Inpatient and OPD staff time (Physical Therapist, Occupational Therapist, Nurse), utilities,



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List of Essential Health Services for Tetralogy of Fallot (TOF) or Closure of VSD with Severe Pulmonary Stenosis

A. Total Correction of Tetralogy of Fallot or VSD with Severe Pulmonary Stenosis

Package Inclusion	Essential Health Services
1. Laboratory/ Diagnostic Tests	CBC Blood typing Prothrombin time Activated partial thromboplastin time Serum Electrolytes (Na, K, iCa, Mg) BUN Creatinine Albumin Chest X-ray (PA Lateral, portable) 12 lead ECG bedside Serum Lactate Arterial Blood Gas (ICU, complete panel, pulmonary) CBG monitoring 2D Echo with Doppler (Transthoracic) Transesophageal Echocardiogram
2. Drugs/ Medicines	Propranolol Furosemide IV, oral ACE inhibitor (Ex. captopril) Spironolactone Digoxin Nicardipine Sodium bicarbonate Sedation and pain: (paracetamol IV, oral, midazolam, propofol, fentanyl) Povidone iodine Antimicrobials: (vancomycin, amikacin, mupirocin) Omeprazole Pulmonary medications: (salbutamol

Package Inclusion	Essential Health Services
	nebule, budesonide nebule, acetylcysteine) Hydrocortisone Hemodynamic support: (nitroglycerin, dobutamine) IVF-Electrolytes (Ex. KCl, Mg_2SO_4, Ca gluconate) Others: dextrose, normal saline solution (NSS), Sterile water for injection (SWI)
3. Ancillary Services	Dietary (caloric requirement) Pulmonary Services: Incentive spirometry Mechanical ventilator use
4. Blood Bank Services	Antibody screening test-patient Hepatitis Screening (Anti-HCV, HBsAg) Cross matching HIV Screening Blood donor antibody screening test (per component) Storage and handling fees Drug assay for blood donor
5. Procedures	TOF repair or VSD closure (Inclusive of perfusion (heart lung machine) Anaesthesia (machine) Anaesthetics (Ex. ketamine)
6. Administrative and Other Fees	Pedia Ward, SICU OR Supplies CSR Supplies

B. Cardiac Rehabilitation Services

Package Inclusion	Essential Health Services
1. Cardiac Rehabilitation	Daily assessment Pre rehabilitation orientation Post rehabilitation discharge instructions
2. Admin and Other Fees	Inpatient and OPD staff time (Physical Therapist, Occupational Therapist, Nurse), utilities

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

Numero ng kaso: _____
Case No.

MEMBER EMPOWERMENT FORM

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

Mga Panuto:
Instructions:

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

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

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

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

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

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

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

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

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

Kategorya bilang Miyembro:
Membership Category:

Direct contributor
Direct contributor

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

Indirect contributor
Indirect contributor

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

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

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

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

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

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For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e. c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. *I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses*		
d. Sakaling ako ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan o tumanggap ng karagdagang serbisyo na hindi kasama sa benepisyo, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan) *In case I choose to upgrade my room accommodation or avail of additional services that are not included in the benefit package, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)*		
e. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth *I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth benefits* f. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa: *I agree to pay as much as PHP _____* for the following:* ☐ Paglipat ko sa mas magandang kuwarto, o *I choose to upgrade my room accommodation, or* ☐ anumang karagdagang serbisyo, tukuyin _____ *additional services, specify* _____ * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.* * Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy.		

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

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

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

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

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

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

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

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

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

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

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Annex E: Z Satisfaction Questionnaire

PhilHealth Z 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 8662-2588. Your responses will be kept confidential and anonymous.

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

1. Z benefit package availed is for:

☐ Acute lymphoblastic leukemia
☐ Breast cancer
☐ Prostate cancer
☐ Kidney transplantation
☐ Cervical cancer
☐ Coronary artery bypass surgery
☐ Surgery for Tetralogy of Fallot
☐ Surgery for ventricular septal defect
☐ ZMORPH/Expanded ZMORPH
☐ Post kidney transplantation services
☐ Orthopedic implants
☐ 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

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

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5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)

☐ excellent
☐ satisfactory
☐ unsatisfactory
☐ don't know

6. In general, how would you rate the health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?

☐ excellent
☐ satisfactory
☐ unsatisfactory
☐ don't know

7. In your opinion, by how much has your HF expenses been lessened by availing of the Z benefit package?

☐ less than half
☐ by half
☐ more than half
☐ don't know

8. Overall patient satisfaction (PS mark) is:

☐ excellent
☐ satisfactory
☐ unsatisfactory
☐ don't know

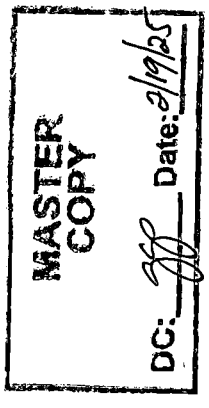
9. If you have other comments, please share them below:

_____

_____

_____

Thank you. Your feedback is important to us!



_____

Signature of Patient/ Parent/ Guardian

Date accomplished: _____

Annex F.1.: Checklist of Requirements for Reimbursement for Open Heart Surgery

PhilHealth
Your Partner in Health

BAGONG PILIPINAS

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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐-☐☐☐☐☐☐☐☐-☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT'

Place a (✓) on appropriate answer; as applicable

Date Filed (mm/dd/yyyy):		
CABG Surgery ☐ Standard Risk ☐ Expanded Risk	Closure of Ventricular Septal Defect ☐ With Associated Special Conditions ☐ Without Associated Special Conditions ☐ With Severe Pulmonary Stenosis	☐ Total Correction of Tetralogy of Fallot

Requirements	Please Check
1. Transmittal Form (Annex G)	
2. Properly accomplished PhilHealth Claim Form (CF) 1 OR PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
3. Photocopy of completely accomplished ME FORM (Annex D)	
4. Photocopy of completed Z Satisfaction Questionnaire (Annex E)	
5. Checklist of Requirements for Reimbursement (Annex F.1)	
6. Photocopy of approved Pre –Authorization Checklist & Request: ☐ Annex A.1: CABG Surgery - Standard Risk and Expanded Risk ☐ Annex A.2: Closure of VSD with or without Associated Special Conditions ☐ Annex A.3: TOF or Closure of VSD with Severe Pulmonary Stenosis	
7. Properly accomplished Checklist of Essential Health Services: ☐ Annex H.1: Coronary Artery Bypass Graft (CABG) ☐ Annex H.2: Closure of VSD with or without Associated Special Conditions ☐ Annex H.3: TOF or Closure of VSD with Severe Pulmonary Stenosis	

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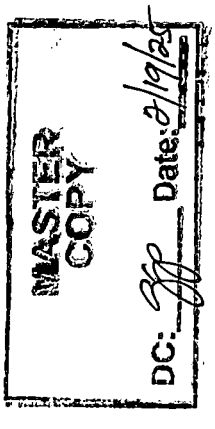
8. Original or Certified true copy of Statement of Account (SOA)	
9. Photocopy of accomplished surgical operative report	
10. Photocopy of accomplished anesthesia report	

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

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



Annex F.2.: Checklist of Requirements for Reimbursement for Post-Cardiac Surgery Services

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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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT

Place a (✓) on appropriate answer; as applicable

Date Filed (mm/dd/yyyy):		
CABG Surgery ☐ Standard Risk ☐ Expanded Risk	Closure of Ventricular Septal Defect ☐ With Associated Special Conditions ☐ Without Associated Special Conditions ☐ With Severe Pulmonary Stenosis	☐ Total Correction of Tetralogy of Fallot

Requirements	Please Check
1. Transmittal Form (Annex G)	
2. Properly accomplished Claim Form 2	
3. Photocopy of completed Z Satisfaction Questionnaire (Annex E)	
4. Checklist of Requirements for Reimbursement for Post-Cardiac Surgery Services (Annex F.2.)	
5. Properly accomplished Checklist of Essential Health Services for Post-Cardiac Surgery Services (Annex H.4.)	
6. Original or Certified true copy of Statement of Account (SOA)	
7. Completed Cardiac Rehabilitation Form	
8. Completed Certificate of OPD Follow-up consultation	

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

MASTER COPY
Date: 2/19/25

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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

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

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DC: Date: 8/19/25

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TRANSMITTAL FORM

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: Z030A
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.

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Date: 2/19/25
DC:

	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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PAB

Annex H.1: Checklist of Essential Health Services for Coronary Artery Bypass Graft (CABG) Surgery

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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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

MASTER COPY Date: 2/19/25

Checklist of Essential Health Services for CABG Surgery Standard Risk and Expanded Risk

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

Essential Health Services	
Mandatory Services	**As needed / As indicated**
Laboratory and Diagnostic Tests	
☐ CBC with platelet	
☐ Blood typing	
☐ Prothrombin time	
☐ Activated partial thromboplastin time	
Electrolytes:	
☐ Sodium (Na)	
☐ Potassium (K)	
☐ Ionized Calcium (iCa)	
☐ Magnesium (Mg)	
☐ Chloride	
☐ BUN	
☐ Creatinine	
☐ Albumin	
	☐ SGPT
	☐ SGOT
☐ Urinalysis	
☐ FBS	
☐ Chest X-ray (PA Lateral)	
☐ 12 lead ECG	

Essential Health Services	
Mandatory Services	**As needed / As indicated**
☐ Arterial blood gas (ABG)	
☐ CBG monitoring	
	☐ 2D echo with doppler
☐ Arterial duplex scan*	
	☐ Chest CT scan*
Treatment	
☐ Incentive spirometry	
☐ Blood products screening	
☐ Mechanical ventilator use	
	☐ Nebulization
	☐ Intra-aortic balloon pump*
	☐ Renal replacement therapy (hemodialysis)*
	☐ Temporary pacemaker*
Drugs/ Medicines	
	Tick appropriate boxes if not given
Antiplatelet ☐ Aspirin OR ☐ Clopidogrel	☐ Contraindicated ☐ Will cause adverse reaction
☐ Statin Specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
☐ Antimicrobials Prophylaxis Specify:_____	☐ Contraindicated ☐ Will cause adverse reaction
	☐ Beta-blockers Specify:_____
	☐ ACE inhibitors or ARB Specify:_____
	☐ Sedation/pain Specify:_____
	☐ Antimicrobials Specify:_____
	☐ Gastrointestinal medications Specify:_____
	☐ Pulmonary medications Specify:_____
	☐ Hemodynamic support Specify:_____
	☐ Electrolytes Specify:_____
☐ Calcium channel blockers Specify:_____	☐ Contraindicated ☐ Will cause adverse reaction
	☐ Digoxin
☐ Heparin* Specify:_____	

Essential Health Services	
Mandatory Services	**As needed / As indicated**
Procedures	
☐ Open heart (CABG) surgery (inclusive of perfusion and anesthesia)	
☐ Immediate postoperative care at surgical ICU	
	☐ Use of Catheter Laboratory* (for IABP insertion)
	☐ Other specialty services as needed, such as pulmonology, nephrology, neurology, infectious disease, etc.

*CABG Surgery - expanded risk

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

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

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

Annex H.2: Checklist of Essential Health Services for Closure of Ventricular Septal Defect (VSD) With or Without Associated Special Conditions

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PHILIPPINE HEALTH INSURANCE CORPORATION
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PhilHealthOfficial teamphilhealth

Case No. _____

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

Checklist of Essential Services for VSD with or without Associated Special Conditions

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

Essential Health Services (As necessary)	
1. Laboratory / Diagnostic Tests	☐ CBC
	☐ Blood typing
	☐ Prothrombin time
	☐ Activated partial thromboplastin time (APTT)
	Serum electrolytes
	☐ Sodium
	☐ Potassium
	☐ Ionized calcium
	☐ Magnesium
	☐ BUN
	☐ Creatinine
	☐ Albumin
	☐ Chest X-ray (PA lateral, portable)
	☐ 12 lead ECG
	☐ Serum lactate
	☐ Arterial blood gas (ABG)
	☐ CBG monitoring
	☐ 2D echo with Doppler (thoracic)
	☐ Transesophageal echocardiogram
2. Drugs/ Medicines	☐ Propranolol
	☐ Furosemide (IV, oral)
	☐ ACE inhibitor Specify: _____

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Essential Health Services (As necessary)	
Drugs/ medicines (Cont'd)	☐ Spironolactone
	☐ Digoxin
	☐ Nicardipine
	☐ Sodium bicarbonate
	☐ Sedation/ pain medications: Specify: _____
	☐ Povidone iodine
	☐ Antimicrobials: Specify: _____
	☐ Omeprazole
	☐ Pulmonary medications: Specify: _____
	☐ Hydrocortisone
	☐ Hemodynamic support: Specify: _____
	☐ Intravenous fluids electrolytes: Specify: _____
	☐ Dextrose
	☐ Normal Saline Solution (NSS)
	☐ Sterile water for injections
3. Ancillary services	☐ Dietary (caloric requirement)
	Pulmonary services:
	☐ Incentive spirometry
	☐ Mechanical ventilator use
4. Blood bank services	☐ Antibody screening test (patient)
	Hepatitis screening
	☐ Anti-HCV
	☐ HBsAG
	☐ Cross matching
	☐ HIV screening
	☐ Blood donor antibody screening test (per component)
	☐ Drug assay (blood donor)
5. Procedures	☐ VSD closure (inclusive of perfusion – heart lung machine)
	☐ Anesthetics Specify: _____

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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number	☐☐ - ☐☐☐☐☐☐☐☐ - ☐

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

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

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

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DC: Date: 2/19/25

Annex H.3: Checklist of Essential Health Services for Tetralogy of Fallot (TOF) or Closure of VSD with Severe Pulmonary Stenosis

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PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2586 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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Checklist of Health Essential Services for Tetralogy of Fallot (TOF) or Closure of VSD with Severe Pulmonary Stenosis

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

Essential Health Services (As necessary)	
1. Laboratory and Diagnostic Tests	☐ CBC
	☐ Blood typing
	☐ Prothrombin time
	☐ Activated partial thromboplastin time (APTT)
	Serum electrolytes:
	☐ Sodium
	☐ Potassium
	☐ Ionized calcium (iCa)
	☐ Magnesium
	☐ BUN
	☐ Creatinine
	☐ Albumin
	☐ Chest x-ray (PA lateral, portable)
	☐ 12 lead ECG
	☐ Serum lactate
	☐ Arterial blood gas (ABG)
	☐ CBG monitoring
	☐ 2D Echo with Doppler (Transthoracic)
	☐ Transesophageal Echocardiogram
2. Drugs/ Medicines	☐ Propranolol
	☐ Furosemide
	☐ Ace inhibitor Specify: _____

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Essential Health Services (As necessary)	
Drugs/ medicines (cont'd)	☐ Spironolactone
	☐ Digoxin
	☐ Nicardipine
	☐ Sodium bicarbonate
	☐ Mupirocin
	☐ Sedation and pain medications Specify:_____
	☐ Povidone iodine
	☐ Antimicrobials Specify:_____
	☐ Omeprazole
	☐ Pulmonary medications Specify:_____
	☐ Hydrocortisone
	☐ Hemodynamic support Specify:_____
	☐ Intravenous fluid (IVF) electrolytes Specify:_____
	☐ Dextrose
	☐ Normal saline solution (NSS)
	☐ Sterile water for injections (SWI)
3. Ancillary Services	☐ Dietary (caloric requirement)
	Pulmonary Services:
	☐ Incentive spirometry
	☐ Mechanical ventilator use
4. Blood bank services	☐ Antibody screening test (patient)
	Hepatitis screening: ☐ Anti-HCV ☐ HBsAG
	☐ Cross matching
	☐ HIV screening
	☐ Blood donor antibody screening test (per component)
	☐ Drug assay for blood donor
5. Procedures	☐ TOF repair or VSD closure (inclusive of perfusion – heart lung machine)
	☐ Anaesthetics: Specify:_____

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 the following only if the patient is a dependent) 1. Last Name, First Name, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

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

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

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Annex H.4: Checklist of Essential Health Services for Post-Cardiac Surgery Services

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PhilHealthOfficial teamphilhealth

Case No. _____

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

Checklist of Health Essential Services for Post-Cardiac Services

Place a check (✓) on the appropriate answer

Type of Surgery Performed	Date of Procedure (mm/dd/yyyy)
☐ Coronary Artery Bypass Graft (CABG) Closure of Ventricular Septal Defect ☐ Without Special Conditions ☐ With Special Conditions ☐ With Severe Pulmonary Stenosis ☐ Repair of Tetralogy of Fallot (TOF)	

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A. Cardiac Rehabilitation Sessions*

	Date Performed (mm/dd/yyyy)	Indicate the health professionals (e.g. Physical Therapist, Occupational Therapist)
1.		
2.		
3.		
4.		
5.		
6.		

*Maximum sessions covered:
Six (6) – CABG
Four (4) – VSD and TOF

B. Ancillary Services for post-CABG Surgery

Essential Health Services	Date Conducted/Dispensed (mm/dd/yyyy)
Laboratory and Diagnostics	
☐ Electrocardiogram (ECG)	
As indicated/needed:	
☐ Cardiac Stress Test	
☐ Complete blood count (CBC)	
☐ Fasting blood sugar (FBS)	
☐ Blood Urea Nitrogen (BUN)	
☐ Serum Creatinine	
Electrolytes: ☐ Sodium ☐ Potassium ☐ Magnesium ☐ Ionized Calcium	
Drugs/ Medicines	
☐ Antiplatelet Specify:_____	
☐ Statins Specify: _____	
As indicated/needed:	
☐ Beta blockers Specify:_____	
☐ Calcium channel blockers Specify:_____	
☐ Nitrates Specify: _____	
☐ Antiplatelet agents Specify: _____	
☐ Angiotensin receptors blockers Specify: _____	
Consultations	
☐ Follow-up visit (Cardiologist or other Specialists)	Date of Visit (mm/dd/yyyy):

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist (Adult or Pediatric)	(Printed name and signature) Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
PhilHealth Accreditation No. ___-___-___	PhilHealth Accreditation No. ___-___-___
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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

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DC: Date: 2/19/25