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

PHILHEALTH HEMODIALYSIS BENEFITS PACKAGE AGREEMENT FORM

HD Treatment Session No. _____
Date (Month/Day/Year) _____

This document is intended to verify that you have received adequate information verbally and in writing, including PhilHealth's guidelines for availing of the benefits package for hemodialysis (HD). The HD facility should clearly explain to you the significance of the contents of this Agreement Form in the language that you understand and will furnish you with a copy of the form for each unique treatment session.

I have been fully informed by Dr./Mr./Ms. _____ of the PhilHealth policies on availing of the benefits package for HD.

I understand that PhilHealth covers up to 156 treatment sessions per calendar year for patients with chronic kidney disease stage 5 (CKD5).

I understand that the HD package provides coverage for the minimum standards required by CKD5 patients, as enumerated in the applicable PhilHealth policy.

I understand that the package rate for HD is PHP 6,350 per treatment session. This includes the fees for the health facility and the professional.

I understand that the provision of the services depends on the patient's status; therefore, I will receive the following services that are clinically indicated and necessary for my treatment session:

Items Covered by PhilHealth	**Put a check (✓) if indicated and a cross mark (x) if not indicated**
Drugs/Medicines	
Epoetin alpha (Human Recombinant Erythropoietin)	
1. 2000 IU/0.5 mL pre-filled syringe	
2. 4000 IU/0.4 mL pre-filled syringe	
3. 4000 IU/mL, 1 mL vial	
4. 4000 IU/mL solution for injection in 1 mL pre-filled syringe	
5. 10,000 IU/mL pre-filled syringe	
Epoetin beta (Recombinant Erythropoietin)	
1. 2000 IU/0.3 mL pre-filled syringe	
2. 5000 IU/0.3 mL pre-filled syringe	
3. 10,000 IU/0.6 mL pre-filled syringe	

Annex A: Agreement Form

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Items Covered by PhilHealth	Put a check (✓) if indicated and a cross mark (x) if not indicated
Iron Sucrose 20 mg/mL, 5 mL ampule	
Heparin	
1. Heparin sodium 1000 IU/mL, 5 mL vial	
2. Heparin sodium 5000 IU/mL, 5 mL vial	
3. Heparin sodium 1000 IU/mL, 30 mL vial	
4. Heparin sodium 5000 IU/mL, 30 mL vial	
Laboratory tests	
1. Complete blood count	
2. Serum creatinine	
3. BUN	
4. Hepatitis profile	
5. Alkaline phosphatase	
6. Potassium	
7. Phosphorus	
8. Calcium	
9. Sodium	
10. Serum iron/ ferritin/ transferrin, total iron binding capacity	
11. Albumin	
Supplies	
Dialyzer, low-flux	
Dialyzer, high-flux	
Hemodialysis Solutions	
Dialysis Kit	
Administrative & Other Fees, specify:	

I understand that I may be charged a copayment for the following items, amenities, additional services, and premium services that are not covered by PhilHealth (attach additional sheet as necessary):

Item	Unit/Quantity	Price (PHP)
		Total

I have been furnished with a list of possible funding sources for medical assistance that may complement the PhilHealth benefits for HD.

Conforme:

_____
Printed name and signature of patient

Date:_____

_____
Printed name & signature
HD Facility Representative

Date: _____

Witness:

_____
Printed Name and signature

Date: _____