Annex C.1: Pre-authorization Checklist and Request Form for Wheelchairs

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._____

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

Place a (✓) if "Yes"

General Criteria	YES
The patient must be at least 18 y/o and above at the time of enrollment to the Benefits Package on Assistive Mobility Device (Wheelchair)	

Place a (✓) if "Yes"

History of Previous Availment ☐ Not Applicable	YES
*If *yes,* indicate the date of last availment Date of last availment of Assistive Mobility Device: Wheelchair (mm/ yyyy) : _____ Name of HF where the wheelchair was previously availed from: _____	

Eligibility Criteria for Assistive Mobility Device: Wheelchair

Place a (✓) if "Yes"

Inability to walk ≤400 meters or endure 10 minutes of continuous walking	☐ Yes
No masses, pressure sores on areas of contact, deformities, or contractures that deter safe & functional use of a wheelchair	☐ Yes

Place a checkmark (✓) on the appropriate type of Assistive Mobility Device based on the descriptive criteria for mobility and self-care, behavioral and communication disabilities, standing balance, sitting static and dynamic balance, and the ability to self-propel.

☐ **Basic Wheelchair**	1. Mild to moderate disability in mobility and self-care 2. Mild to moderate cognitive/ behavioral & communication disability 3. Absent to poor standing balance 4. Fair to good sitting static and dynamic balance 5. Cannot self-propel wheelchair
☐ **Active Wheelchair**	1. Mild to moderate disability in mobility and self-care 2. No cognitive/ behavioral & communication disability 3. Normal to good sitting balance 4. Good sitting dynamic and static balance & endurance 5. Able to self-propel wheelchair
☐ **Supportive Wheelchair**	1. Moderate to severe disability in mobility and self-care 2. Moderate to severe cognitive/ behavioral & communication disability 3. Absent to poor standing balance 4. Absent to poor sitting balance 5. Cannot self-propel wheelchair
☐ **Motorized Wheelchair**	1. Mild to moderate disability in mobility and self-care 2. Mild behavior/cognitive & communication disability 3. Normal to good sitting balance 4. Good sitting dynamic and static balance 5. Cannot self-propel wheelchair

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist/Physiatrist	(Printed name and signature) Patient
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
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 Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the **Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices.** Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy):
This is to request approval for provision of services under the **Physical Medicine, Rehabilitation Services, and Assistive Mobility Devices** 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 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:													
(Printed name and signature) Attending Physical Medicine and Rehabilitation Specialist													
PhilHealth Accreditation No.					.							.	

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

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

<table>
<tr><th colspan="3">INITIAL APPLICATION</th><th colspan="3">COMPLIANCE TO REQUIREMENTS</th></tr>
<tr><th>Activity</th><th>Initial</th><th>Date</th><td colspan="3" rowspan="2">☐ APPROVED
☐ DISAPPROVED (State reason/s)
_____
(Printed name and signature)
Head or authorized BAS representative</td></tr>
<tr><td>Received by LHIO/BAS:</td><td></td><td></td></tr>
<tr><td>Endorsed to BAS (if received by LHIO):</td><td></td><td></td><td colspan="3" rowspan="2"></td></tr>
<tr><td rowspan="2">☐ Approved
☐ Disapproved</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><th>Activity</th><th>Initial</th><th>Date</th></tr>
<tr><td>Released to HF:</td><td></td><td></td><td>Received by BAS:</td><td></td><td></td></tr>
<tr><td colspan="3" rowspan="2">The pre-authorization shall be valid for sixty (60) calendar days</td><td>☐ Approved ☐ Disapproved</td><td></td><td></td></tr>
<tr><td>Released to HF:</td><td></td><td></td></tr>
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