

## RRepublic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center (02) 441-7442 Trunkline (02) 441-7444 <u>www.philhealth.gov.ph</u>

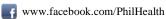


Case No								
		Annex "A – RF/RHD	,,					
HEALTH CA	RE INSTITUTION (HCI)							
ADDRESS OF	F HCI							
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX ☐ Male ☐ Female							
	2. PhilHealth ID Number -							
B. MEMBER (answer only if	1. Last Name, First Name, Middle Name, Suffix							
the patient is a dependent)	2. PhilHealth ID Number		]					
Fulfilled selections criteria								
PRE-AUTHORIZATION CHECKLIST Rheumatic Fever/Rheumatic Heart Disease								
QUALIFICA'	TION							
Place a check n	mark (✔) for the Stage of the Disease	Stage:						
Fulfills any of	the following criteria:							
Echocardiograpplicable):	ram finding (tick one, whichever is	Date/s of 2D-echo	Date/s of 2D-echo					
☐ Fulfills	Modified Jones Criteria Il to Stage A valve involvement							
☐ Definit Progres	te RHD Echo Stage B ssive Valve Disease							
☐ Definit	al LV size and function te RHD Stage C							
Modera Left ve								
	art failure onal Class I-II							

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Echocardiogram finding (Continuation)	Date/s of 2D-echo					
☐ Definite RHD Stage D						
Severe valve involvement or multiple						
Left ventricle enlargement						
With heart failure						
Functional Class III-IV						
Treatment Plan: choose one						
☐ Secondary prevention intramuscular, Pen	icillin G Choose one					
benzathine (benzathine benzylpenicillin)	□ every 21 days					
OR	□ every 28 days					
☐ Secondary prophylaxis with oral medicati	on Choose one					
	□ phenoxymethyl penicillin					
	(penicillin V)					
	erythromycin					
Certified correct by Attending Physician:						
Printed name and signature  PhilHealth Accreditation No.						
Note: Once approved, the contracted HCI shall print the appr by the parent or guardian and health care providers, as PhilHealth Regional Office (PRO) or the Local Health tranche. There is no need to attach laboratory results. However, may be checked during the field monitoring of the RF/RI	applicable. This form shall be submitted to the in Insurance Office (LHIO) when filing the first these should be included in the patient's chart and					



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## PRE-AUTHORIZATION REQUEST Rheumatic Fever/Rheumatic Heart Disease

DATE OF REQUEST (mm/dd/yyyy):								
This is to request approval for provision of services under the outpatient benefit package for the secondary prevention of RF/RHD								
(NAME OF PATIENT) in (NAME OF HCI)								
under the terms and conditions as agreed for availment of the said benefit package.								
The patient belongs to the following category (please tick appropriate box):  □ No Balance Billing (NBB) □ Co-pay								
Certified correct by:			Certified correct by:					
(Printed name and signature)			(Printed name and signature)					
Attending Physic			Executive Director/Chief of Hospital/					
)			Medical Director/ Medical Center Chief					
PhilHealth Accreditation No.		_	PhilHealth Accreditation No.		_			
	1 1 1 1							
			Conforme by:					
			(Printed name and signature)					
			Parent/Guardian					
	(Fo	r PhilHe	alth Use Only)					
□ APPROVED								
☐ DISAPPROVED (State rea	ason/s) <sub>-</sub>							
(Printed name and signature)								
Authorized Personnel, Benefit	s Admin	istration	Section (BAS)					
INITIAL APPLICAT	TION		COMPLIANCE TO REQUIREMENTS					
Activity	Initial	Date	□ APPROVED					
Received by LHIO/BAS:			☐ DISAPPROVED (State reason	on/s)				
Endorsed to BAS (if received by LHIO):								
☐ Approved ☐ Disapproved			Activity	Initial	Date			
Released to HCI:			Received by BAS:					
This pre-authorization is valid within 12 months		☐ Approved ☐ Disapproved						
from date of approval of request.		Released to HCI:						

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