

Annex A.1.: Pre-authorization Checklist and Request Form For Kidney Transplant Recipient - Pediatric



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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 PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)	
ADDRESS OF HF	
A. PATIENT	Last Name, First Name, Middle Name, Suffix SEX <input type="checkbox"/> Male <input type="checkbox"/> Female PhilHealth ID Number: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
B. MEMBER <input type="checkbox"/> Same as above (Answer only if the patient is a dependent)	Last Name, First Name, Middle Name, Suffix SEX <input type="checkbox"/> Male <input type="checkbox"/> Female PhilHealth ID Number: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

(Place a ✓ on the appropriate answer)

History of Kidney Transplantation	
<input type="checkbox"/> Living Organ Donor: <input type="checkbox"/> Related <input type="checkbox"/> Non-Related	<input type="checkbox"/> Deceased Organ Donor
Name of the Kidney Transplant Facility: _____	
Address of the Kidney Transplant Facility: _____	
Date of kidney transplantation (mm/dd/yyyy): _____	

Place a check mark (✓) on the appropriate remarks

General Criteria	Remarks
1. 0 to 18 years old and 364 days	<input type="checkbox"/> Yes
2. Filipino CKD5 patients was transplanted in any DOH licensed transplant facility or PhilHealth accredited health facility	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If kidney transplantation was performed in a foreign country, the patient (Filipino citizen) submitted both of the following documents: <input type="checkbox"/> Medical abstract translated into an English version <input type="checkbox"/> Filipino Dual Citizenship Certificate (as applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> NA
4. Ability to follow prescribed medication regimens, particularly immunosuppressive therapy or availability of family or caregiver support in assisting patient's compliance to medical treatment.	<input type="checkbox"/> Yes
5. If the patient was enrolled in the post-KT services and declared lost to follow-up: Reason/s for lost to follow-up (specify): _____	<input type="checkbox"/> Yes <input type="checkbox"/> NA



Certified correct by:	Conforme by:
(Printed name and signature) Attending Nephrologist/Transplant Surgeon	(Printed name and signature) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian
PhilHealth Accreditation No. _____	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 Z Benefits. Please do not leave any item blank.

PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy): _____

This is to request approval for provision of services under the Z Benefits 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:	Conforme by:
(Printed name and signature) Attending Nephrologist/Transplant Surgeon	(Printed name and signature) <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian
PhilHealth Accreditation No. _____	PhilHealth Accreditation No. _____

Conforme by:
(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief/ Authorized Signatory
PhilHealth Accreditation No. _____

 (For PhilHealth Use Only)

- APPROVED
 DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	Initial	Date			
Received by LHIO/BAS:			<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED (State reason/s) _____ (Printed name and signature) Head or authorized BAS representative		
Endorsed to BAS (if received by LHIO):					
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved			Activity	Initial	Date
Released to HF:			Received by BAS:		
The pre-authorization shall be valid for one hundred eighty (180) calendar day			<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		
			Released to HF:		