

Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center: (02) 8441-7442 Trunkline: (02) 8441-7444 www.philhealth.gov.ph



Case No.								
Case No.								
	Anne	x "A – ALL"						
HEALTH CAI	RE PROVIDER (HCP)							
	and they in the first of the fi							
ADDRESS OF	F HCP							
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix SEX \square Ma	ıle 🗆 Female						
	2. PhilHealth ID Number	-						
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent)	1						
	1. Last Name, First Name, Middle Name, Suffix							
	2. PhilHealth ID Number -	<u> </u>						
Fulfilled sele	Fulfilled selections criteria Yes If yes, proceed to pre-authorization application No If no, specify reason/s and encode							
PRE-AUTHORIZATION CHECKLIST Acute Lymphocytic/Lymphoblastic Leukemia Standard Risk								
	Place a c	heck mark (✓)						
QUALIFICA'	I'ION	YES						
Age 1 to 10 year	ars and 364 days							
	Conforme by Parent/	Guardian:						
	Printed name and	l signature						
ATTESTED	BY ATTENDING PHYSICIAN	hools mouls (V)						
QUALIFICA		heck mark (✔) YES						
	narrow aspirate morphology ALL FAB L1 or L2*	1120						
	S involvement based on:							
a.	CSF cell count and differential count							
b.	Clinical findings							
	no testicular involvement	†						

^{*} L3 morphology is excluded



If female, put "N/A"

Place a check mark (✓)

DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
CBC WBC count $<50,000/\mu$ L or $<50,000$ cells/ μ L or <50 x $10^3/\mu$ L or <50 x $10^9/$ L		
CSF cell count white blood cell (WBC) not more than 5 x 10 ⁶ /L		

Certified correct by A	Attending Physician:

	Print	ed n	am	e a	ınc	l si	ign	atı	ıre	;		
PhilHealth Accreditation No.				_							_	

Note:

Once approved, the contracted HCP shall print the approved pre-authorization form and have this signed by the parent or guardian and healthcare 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.







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PRE-AUTHORIZATION REQUEST Acute Lymphocytic/Lymphoblastic Leukemia (Standard Risk)

DATE OF REQUEST (mm/	dd/yyyy)):							
This is to request approval for	provisio	on of serv	vices under the Z benefit packag	ge for					
		:	in						
(Patient's last, first, suffix, middle name) (Name of HCP)									
under the terms and condition	s as agre	ed for av	vailment of the Z Benefit Packag	ge.					
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 si		9	(Printed name and signature)						
Attending Physic	cian		Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief						
PhilHealth Accreditation No.			PhilHealth Accreditation No.						
			Conforme by:						
			(Printed name and signature)						
			Parent/Guardian						
	(Fo	r PhilHe	alth Use Only)						
□ APPROVED	,		3,7						
☐ DISAPPROVED (State re	ason/s)								
(Printed name and signatur	re)								
Head or authorized representative,	,	Adminis	tration Section (BAS)						
INITIAL APPLICAT	ΓΊΟΝ		COMPLIANCE TO REQ	UIREME	NTS				
Activity	Initial	Date							
Received by LHIO/BAS:			☐ DISAPPROVED (State reason/s)						
Endorsed to BAS									
(if received by LHIO):			(Printed name and signature) Head or authorized BAS representative						
☐ Approved ☐ Disapproved			Activity	Initial	Date				
Released to HCP:			Received by BAS:						
This pre-authorization is valid for	This pre-authorization is valid for sixty (60)								
calendar days from date of approval of request.			Released to HCP:						

