Case No. _____

Annex "A – ALL"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

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 check mark (✓)

QUALIFICATION	YES
Age 1 to 10 years and 364 days	

Conforme by Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING PHYSICIAN

Place a check mark (✓)

QUALIFICATIONS	YES
1. Bone marrow aspirate morphology ALL FAB L1 or L2*	
2. No CNS involvement based on: a. CSF cell count and differential count	
b. Clinical findings	
3. If male, no testicular involvement	

* L3 morphology is excluded

Place a check mark (✓)

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

Certified correct by Attending Physician:

_____

Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the 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.

RRepublic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

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

Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

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

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (NAME OF HCI) under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

☐ No Balance Billing (NBB)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Physician	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:

(Printed name and signature)
Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		