Annex A – “Breast CA”

HEALTH CARE INSTITUTION (HCI)

ADDRESS OF HCI

PATIENT (Last name, First name, Middle name, Suffix)

<table>
<thead>
<tr>
<th>PHILHEALTH ID NUMBER OF PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
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</tbody>
</table>

MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

<table>
<thead>
<tr>
<th>PHILHEALTH ID NUMBER OF MEMBER</th>
</tr>
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<tbody>
<tr>
<td>-</td>
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</tbody>
</table>

Fulfilled selections criteria  

- Yes  If yes, proceed to pre-authorization application
- No  If no, specify reason/s and encode

PRE-AUTHORIZATION CHECKLIST
Early Breast Cancer

Place a check mark (√)

QUALIFICATIONS

1. No previous chemotherapy for breast cancer
2. No previous radiotherapy for breast cancer

Place a (√) if YES

CLINICAL STAGE  
(Choose only one except when breast cancer is bilateral)  
(Early breast cancer definitions. Source: AJCC-NCCN 2014)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Tis (carcinoma-in-situ) N0 M0</td>
</tr>
<tr>
<td>IA</td>
<td>T1 (tumor ≤20mm) N0 M0</td>
</tr>
<tr>
<td>IB</td>
<td>T0 N1mi M0; T1 (tumor ≤20mm) N1mi M0</td>
</tr>
<tr>
<td>IIA</td>
<td>T0 N1 M0; T1 N1 M0; T2 (tumor &gt;20mm but ≤50mm) N0 M0</td>
</tr>
<tr>
<td>IIB</td>
<td>T2 N1 M0; T3 (tumor &gt;50mm) N0 M0</td>
</tr>
<tr>
<td>IIIA</td>
<td>T3 N1</td>
</tr>
</tbody>
</table>

Certified correct by Attending Medical Oncologist: 

Certified correct by Attending Surgeon: 

Conforme by Patient: 

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 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**

**Early Breast Cancer**

**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 HCl) 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: ________________________________

(Printed name and signature) Attending Surgeon

Certified correct by: ________________________________

(Printed name and signature) Attending Medical Oncologist

PhilHealth Accreditation No. ____________________________

Conforme by: ________________________________

(Printed name and signature) Patient

Certified correct by: ________________________________

(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief

PhilHealth Accreditation No. ____________________________

- [ ] APPROVED
- [ ] DISAPPROVED (State reason/s) ________________________________

Head, Benefits Administration Section (BAS)

<table>
<thead>
<tr>
<th>INITIAL APPLICATION</th>
<th>COMPLIANCE TO REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Initial</td>
</tr>
<tr>
<td>Received by LHIO/BAS:</td>
<td></td>
</tr>
<tr>
<td>Endorsed to BAS (if received by LHIO):</td>
<td></td>
</tr>
<tr>
<td>Approved</td>
<td>Disapproved</td>
</tr>
<tr>
<td>Released to HCI:</td>
<td></td>
</tr>
</tbody>
</table>

This pre-authorization is valid for sixty (60) calendar days from date of approval of request.

- [ ] Approved | Disapproved

Released to HCI: