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

Case No. _____

Annex A – "Breast CA"

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
Early Breast Cancer

Place a check mark (✓)

QUALIFICATIONS	**Yes**
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)*	**Right**	**Left**
cStage 0: Tis (carcinoma-in-situ) N0 M0		
cStage IA: T1 (tumor≤20mm) N0 M0		
cStage IB: T0 N1mi M0; T1 (tumor≤20mm) N1mi M0		
cStage IIA: T0 N1 M0; T1 N1 M0; T2 (tumor>20mm but ≤50mm) N0 M0		
cStage IIB: T2 N1 M0; T3 (tumor>50mm) N0 M0		
cStage IIIA: T3 N1		

Certified correct by Attending Medical Oncologist:	Certified correct by Attending Surgeon:	Conforme by Patient:
Printed name and signature	Printed name and signature	Printed name and signature
PhilHealth Accreditation No. ☐☐☐☐–☐☐☐☐☐☐☐–☐	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.

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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 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 Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.

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

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

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

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