Annex A.2: Pre-authorization Checklist and Request Form

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐-☐☐☐☐☐☐☐☐-☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐-☐☐☐☐☐☐☐☐-☐	

(Place a ✓opposite appropriate answer)

History of Previous Treatment ☐ Not Applicable	**Date of Procedure or Last Session or Cycles (mm/dd/yyyy)**
☐ Surgery (Specify Site): _____	
☐ Hormonal Therapy	
☐ Cytotoxic Chemotherapy	
☐ Targeted Therapy (Specify Number of Cycles Provided): _____	

(Place a ✓opposite appropriate answer)

Menstrual Stage	
☐ Pre-menopausal	☐ Post-menopausal
HER2 Status	
☐ 0 – 1+ (HER2 Negative)	☐ 2+ (Borderline) ☐ 3+ (HER2 Positive)

(Place a ✓opposite appropriate answer)

Laterality and Clinical Staging [a]	
☐ **Right**	☐ **Left**
☐ cStage 0	☐ cStage 0
☐ cStage IA	☐ cStage IA
☐ cStage IB	☐ cStage IB
☐ cStage IIA	☐ cStage IIA
☐ cStage IIB	☐ cStage IIB
☐ cStage IIIA	☐ cStage IIIA
☐ cStage IIIB	☐ cStage IIIB
☐ cStage IIIC	☐ cStage IIIC
☐ cStage IV	☐ cStage IV

[a] If bilateral, tick in the appropriate box both laterality and its corresponding clinical staging

(Place a ✓opposite appropriate answer)

Applicable Treatment Protocol	
Surgery	☐ Adjuvant ☐ Neoadjuvant
☐ Hormonal Therapy	
Cytotoxic Chemotherapy	☐ Adjuvant ☐ Neoadjuvant Protocol: ☐ Doxorubicin (A) + Cyclophosphamide (C) + Docetaxel (T) ☐ Doxorubicin (A) + Cyclophosphamide (C) + Paclitaxel (Pacli) ☐ Docetaxel (T) + Carboplatin (Cb)
☐ Targeted Therapy	If with previous targeted therapy Specify number of cycles to be provided: _____
☐ Surveillance	

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	**(Answer only if the patient is a dependent; otherwise, write, "same as above")** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Certified Correct by Attending Medical Oncologist:

Printed Name and Signature
PhilHealth Accreditation No.
☐☐☐☐.☐☐☐☐☐☐.☐☐

Certified Correct by Attending Surgeon:

Printed Name and Signature
PhilHealth Accreditation No.
☐☐☐☐.☐☐☐☐☐☐.☐☐

Certified Correct by Attending Radiologic Oncologist:

Printed Name and Signature
PhilHealth Accreditation No.
☐☐☐☐.☐☐☐☐☐☐.☐☐

Conforme by:

Printed Name and Signature
Patient

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
Breast Cancer

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit 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:	Certified Correct by:
(Printed Name and Signature) Attending Medical Oncologist	(Printed Name and Signature) Attending Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Certified Correct by:	Certified Correct by:
(Printed Name and Signature) Attending Radiologic Oncologist	(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) Patient

(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**	☐ APPROVED ☐ DISAPPROVED (State reason/s) _____ (Printed name and signature) Head or authorized BAS representative		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐Approved ☐Disapproved			**Activity**	**Initial**	**Date**
Released to HF:			Received by BAS:		
The pre-authorization for chemotherapy (neoadjuvant) and surgery (adjuvant) shall be valid for 60 calendar days.			☐ Approved ☐Disapproved		
			Released to HF:		