*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

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

**Case No.** _____

**Annex A – "Breast CA"**

| | | |
|---|---|---|
| HEALTHCARE *PROVIDER (HCP)* | | |
| ADDRESS OF *HCP* | | |
| A. PATIENT | 1. Last Name, First Name, Suffix, Middle Name | *SEX* ☐ *Male* ☐ *Female* |
| | 2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐ | |
| B. MEMBER | ☐ *Same as patient* *(Answer the following only if the patient is a dependent)* | |
| | 1. Last Name, First Name, Suffix, Middle Name | |
| | 2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐ | |

**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 v1.2022)* | Right | Left | Both |
|---|---|---|---|
| cStage 0: Tis (*ductal* 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: *T0 N2 M0; T1 N2 M0; T2 N2 M0; T3 N1 M0; T3 N2 M0* | | | |

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.
☐☐☐☐–☐☐☐☐☐☐☐–☐☐

Conforme by Patient:

_____
Printed name and signature

**Note**:
Once approved, the contracted *HCP* 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 _____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HCP*)
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)<br>Attending Surgeon | (Printed name and signature)<br>Attending Medical Oncologist |
| PhilHealth Accreditation No. | PhilHealth Accreditation No. |

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

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(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
*Head or authorized representative*, Benefits Administration Section (BAS)

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

**COMPLIANCE TO REQUIREMENTS**

☐ APPROVED
☐ DISAPPROVED (State reason/s)

_____
*(Printed name and signature)*
*Head or authorized BAS representative*

| **Activity** | **Initial** | **Date** |
|---|---|---|
| Received by BAS: | | |
| ☐ Approved ☐ Disapproved | | |
| Released to *HCP*: | | |