Republic 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 – CABG"

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
Standard Risk Elective Coronary Artery Bypass Graft (CABG) Surgery

Place a check mark (✓)

QUALIFICATIONS	YES
At least 19 years of age	

ATTESTED BY ATTENDING CARDIOLOGIST or CARDIOVASCULAR SURGEON

Place a check mark (✓)

QUALIFICATIONS	YES
1. Stable coronary artery disease requiring ELECTIVE ISOLATED CABG with indication based on coronary anatomy, symptom severity, left ventricular function, and/or viability tests; non-invasive testing completed and discussed with patient	
2. Check current medical status: a. NOT in severe decompensated heart failure by New York Functional Classification (NYFC IV)	
b. NOT with severe angina by Canadian Cardiovascular Society (CCS Class IV)	
c. NO other cardiac/vascular procedures/interventions planned to be done with coronary artery bypass graft surgery during this admission	
d. NO history of dialysis and NO current requirement of dialysis	

3. Based on past history: a. NO previous thoracic/cardiac surgery through median sternotomy	
b. NO previous transcutaneous cardiac intervention within 30 days before contemplated schedule of coronary artery bypass graft surgery	
4. ONLINE EUROSCORE II and Society of Thoracic Surgeons (STS) scoring predictive of low mortality risk (< 5%)	

Place a check mark (✓)

DIAGNOSTICS*	YES	DATE DONE (mm/dd/yy)
1. Coronary Angiography: coronary anatomy amenable for CABG and consistent with Class I and IIa indications for CABG surgery and discussed with patient		
2. Current status of myocardial viability consistent with benefit from CABG and discussed with patient		

*Must be done at least within one fiscal (1) year from date of receipt of pre-authorization checklist and request by the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO).

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

Note:
Once approved, the contracted hospital 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 LHIO or 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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Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

PRE-AUTHORIZATION REQUEST
Standard Risk Elective Coronary Artery Bypass Graft (CABG) Surgery

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 Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
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 one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		