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

Case No. _______________

Annex "A – Cervical CA"

HEALTH CARE *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
Cervical Cancer

Place a check mark (✓)

QUALIFICATIONS	YES
1. Biopsy result	
2. No previous radiotherapy for cervical cancer	
3. No previous chemotherapy for cervical cancer	
4. Treatment plan	
5. No uncontrolled co-morbid conditions	

Place a check mark (✓)

FIGO Clinical Staging	YES	DATE DONE (mm/dd/yyyy)
Stages: (Choose only one)		
Stage IA1		
Stage IA2		
Stage IB1		
Stage IB2		
Stage IIA1		
Stage IIA2		
Stage IIB		
Stage IIIA		
Stage IIIB		

Certified correct by Attending Gynecologic-Oncologist:

____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

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
Cervical 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 belongs to the following category (please tick appropriate box):

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):	Treatment modality: (tick appropriate box)
☐ *Without co-payment* ☐ *With co-payment, for the purpose of:* ____________________	☐ chemoradiation: chemotherapy, cobalt and brachytherapy (low dose) or primary surgery for stage IA1, IA2-IIA1 ☐ chemoradiation: chemotherapy, linear accelerator and brachytherapy (low/high dose)

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Gynecologic-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 *HCP*:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HCP*:		

PhilHealthofficial teamphilhealth actioncenter@philhealth.gov.ph