Case No. _____

Annex "A – Developmental Disability"

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
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

Place a (✓) if yes

	General Qualifications	Yes
1.	The child's chronological age is 0 to 17 years and 364 days old	
2.	The child presents with functional problems secondary to delays, regressions, or deviations in <u>any</u> one of the following developmental domains: ☐ Cognitive-adaptive ☐ Motor ☐ Social ☐ Emotional ☐ Behavioral	
3.	The child was assessed by <u>any</u> or both of the following medical specialists: ☐ Physiatrist/ Rehabilitation Medicine Specialist ☐ Behavioral Developmental Pediatrician or Neurodevelopmental Pediatrician	

Place a (✓) on the appropriate box/es for the appropriate assessment/s or evaluation/s that will be given to the child:
☐ Speech Therapy Assessment ☐ Occupational Therapy Assessment ☐ Physical Therapy Assessment

Conforme by Patient/Parent/Guardian:

_____

Printed name and signature

Attested by Attending Medical Specialist

_____

Printed name and signature

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

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 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.

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

PRE-AUTHORIZATION REQUEST
Z BENEFITS FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for _____ in _____
(NAME OF PATIENT) (NAME OF HOSPITAL)
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

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Medical Specialist	(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/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Authorized Personnel, 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 (1) fiscal year from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		