Case No. ______________

Annex “A – Developmental Disability”

<table>
<thead>
<tr>
<th>HEALTH CARE INSTITUTION (HCI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF HCI</td>
</tr>
<tr>
<td>PATIENT (Last name, First name, Middle name, Suffix)</td>
</tr>
</tbody>
</table>

### 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**

<table>
<thead>
<tr>
<th>General Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place a (✓) if yes</td>
</tr>
</tbody>
</table>

1. The child’s chronological age is 0 to 17 years and 364 days old  
   Yes

2. The child presents with functional problems secondary to delays, regressions, or deviations in **any** one of the following developmental domains:
   - Cognitive-adaptive
   - Motor
   - Social
   - Emotional
   - Behavioral
   Yes

3. The child was assessed by **any** or both of the following medical specialists:
   - Physiatrist/ Rehabilitation Medicine Specialist
   - Behavioral Developmental Pediatrician or Neurodevelopmental Pediatrician
   Yes
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.
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 ____________________________________________ 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:

(Printed name and signature)
Attending Medical Specialist

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/
Medical Director/ Medical Center Chief

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(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) ____________________________________________

(Printed name and signature)
Authorized Personnel, Benefits Administration Section (BAS)

<table>
<thead>
<tr>
<th>INITIAL APPLICATION</th>
<th>COMPLIANCE TO REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Initial</td>
</tr>
<tr>
<td>Received by LHIO/BAS:</td>
<td></td>
</tr>
<tr>
<td>Endorsed to BAS (if received by LHIO):</td>
<td></td>
</tr>
<tr>
<td>☐ Approved ☐ Disapproved</td>
<td></td>
</tr>
<tr>
<td>Released to HCI:</td>
<td></td>
</tr>
<tr>
<td>This pre-authorization is valid for one (1) fiscal year from date of approval of request.</td>
<td></td>
</tr>
</tbody>
</table>

As of September 2017