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. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	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 FOR EXPANDED ZMORPH
Lower Limb Orthosis

Place a (✓) if yes or NA if not applicable

	GENERAL QUALIFICATIONS	Yes
1.	Age ≥ 18 years old	
2.	At least 3 months post-onset	
3.	Upper limbs ≥ 4 with fair trunk control and full range of motion, if bilateral	
4.	Unaffected limbs ≥ 3 with fair trunk control and full range of motion, if unilateral	
5.	Ambulatory with assistive device	
6.	No fresh or non-healing wound	

Place a (✓) if yes or NA if not applicable

	QUALIFICATIONS SPECIFIC TO ANKLE FOOT ORTHOSIS	Yes
1.	Weakness or absence of dorsiflexors *and*/or plantarflexors, +/- grade 1-2 spasticity with full range of motion achieved passively	
2.	Equinovarus +/- foot rotation and +/- grade 1-2 spasticity with full range of motion achieved passively	
3.	Pain & Instability secondary to sensory or structural deficit in a Charcot Arthropathy	

Place a (✓) if yes or NA if not applicable

QUALIFICATIONS SPECIFIC TO KNEE ANKLE FOOT ORTHOSIS	Yes
Quadriceps MMT of <3 +/- sensory loss ,+/- instability (genu recurvatum) with hip/knee flexion contracture <20 degrees	

Place a (✓) if yes or NA if not applicable

QUALIFICATIONS SPECIFIC TO HIP KNEE ANKLE FOOT ORTHOSIS	Yes
Hip, knee, ankle & foot muscles MMT <3 +/- sensory loss, +/- instability, with hip /knee flexion contracture <20 degrees	

Place a check mark (✓) on the type of orthoses to be given to the patient:

Z Benefits	Right	Left	Both
Ankle Foot Orthosis			
Knee Ankle Foot Orthosis			
Hip Knee Ankle Foot Orthosis			

Conforme by Patient/Parent/Guardian:

_____

Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

_____

Printed name and signature

PhilHealth Accreditation No. [ ][ ][ ][ ] – [ ][ ][ ][ ][ ][ ][ ] – [ ]

Note:
Once approved, the contracted *health facility* 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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UNIVERSAL HEALTH CARE

PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH
Lower Limb Orthosis

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z *Benefits* package for

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HF*)
under the terms and conditions as agreed for availment of the Z *Benefits* Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the *benefits* 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) Attending Rehabilitation Medicine 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)
Head or authorized representative, 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 *HF*:			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 *HF*:		