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
Spinal Orthosis

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

	General Qualifications	Yes
1.	Age ≥ 18 years old	
2.	Upon diagnosis and/or post-operative clearance	
3.	No sensory deficit over body segment of application	
4.	Upper and lower limb manual muscle strength of ≥ 3	

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

	Qualifications for Thoracolumbosacral Spinal Orthosis	Yes
1.	Thoracolumbar (T12-L2) spinal fractures involving posterior elements	
2.	Primary or metastatic lesions to the thoracolumbosacral spine	

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

	Qualifications for Lumbosacral Spinal Orthosis	Yes
1.	Lumbosacral fractures (L1-L3)	
2.	Primary or metastatic lesions to the lumbosacral spine	

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

	Qualifications for Cervicothoracic Spinal Orthosis	Yes
1.	Cervical spine fractures (C3-C7) without neurologic deficit	
2.	Torticollis	
3.	Metastatic lesions without neurologic deficit	

Tick the box corresponding to the type of spinal orthosis to be given to the patient:

☐ Thoracolumbosacral custom molded spinal orthosis
☐ Lumbosacral custom molded spinal orthosis
☐ Cervicothoracic custom molded spinal 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 facilities* 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) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH
Spinal 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		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HF*:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HF*:		

PhilHealthofficial teamphilhealth actioncenter@philhealth.gov.ph