## Annex A.3: EMORPH Pre-Authorization Checklist: Spinal Orthosis

Revised as of September 2022



# 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

Cas	se No							
НЕ	ALTH FA	CILITY (HF)						
AD	DRESS OF	FHF						
A. I	PATIENT	SEX □ Male □ Female						
	2. PhilHealth ID Number							
В. М	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								
	C 10		NA if not applicable					
1.		Qualifications	Yes					
2.	Age ≥ 18	gnosis and/or post-operative clearance						
3.		asory deficit over body segment of application						
4.	Upper and lower limb manual muscle strength of ≥ 3							
			NA if not applicable					
	Yes							
1.		ımbar (T12-L2) spinal fractures involving posterior elemen	ts					
2.	Primary o	r metastatic lesions to the thoracolumbosacral spine						
		Place a (✔) if yes or	NA if not applicable					
	Qualifica	tions for Lumbosacral Spinal Orthosis	Yes					
1.		osacral fractures (L1-L3)						
2.	Primary o	ry 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	

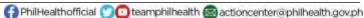
Tick the box corresponding to the type of spinal orthosis to be given to the patient:									
<ul> <li>☐ Thoracolumbosacral custom molded spinal orthosis</li> <li>☐ Lumbosacral custom molded spinal orthosis</li> <li>☐ Cervicothoracic custom molded spinal orthosis</li> </ul>									
Conforme by Patient/Parent/Guardian:		Attested by Attending Rehabilitation Medicine Specialist							
Printed name and signature	PhilHealth Accreditation No.	Printed name and signature							

#### 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.









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### PRE-AUTHORIZATION REQUEST FOR EXPANDED ZMORPH **Spinal Orthosis**

DATE OF R	EQUES'	T (mm/	dd/yyyy)	:							
This is to requ	uest appr	oval for	provisio	n of serv	rices under the Z Benefits packag	e for					
(Pation	inin										
(Patient's last, first, suffix, middle name) (Name of HF) under the terms and conditions as agreed for availment of the Z Benefits Package.											
and the terms and conditions as agreed for available of the B being a factorized.											
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:											
C: C1		-#		- //	Ct:C1						
Certified corr	ect 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  alth Use Only)						
☐ APPROV☐ DISAPPR		(State re	ason /s)								
<b>D</b> 13/1111	OVED	(State 10	as011/ s) .								
(Printed name and signature) Head or authorized representative, Benefits Administration Section (BAS)											
INITIAL APPLICATION					COMPLIANCE TO REQUIREMENTS						
Activity			Initial	Date	□ APPROVED						
Received by LHIO/BAS:				☐ DISAPPROVED (State reaso	on/s)						
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					☐ Approved ☐ Disapproved						
eighty (180) calendar days from date of approval				proval	Released to HF:						





