

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



Case No.

Annex "A – Hearing Impairment"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT
MEMBER (answer only if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER
Fulfilled selections criteria Tes If yes, proceed to pre-authorization application No If no, specify reason/s and encode

PRE-AUTHORIZATION CHECKLIST Z BENEFITS FOR CHILDREN WITH HEARING IMPAIRMENT

Place a (\checkmark) in the status column if yes

	General Qualifications	Status
1.	The child's age is 0 to 17 years and 364 days old	
2.	The child must have undergone professional assessment and was diagnosed	
	to have all of the following :	
	□ Presence of delay on auditory milestones and/or communication issues	
	at home/school	
	\Box Sensorineural hearing loss presenting with either moderate or severe to	
	profound hearing loss (Tick one)	
	□ Moderate hearing loss	
	□ Severe - Profound hearing loss	
	\square No signs and symptoms of an active ear infection	

Conforme by Patient/Parent/Guardian:

Attested by Attending Otolaryngologist

Printed name and signature

PhilHealth
Accreditation No.

Printed name and signature

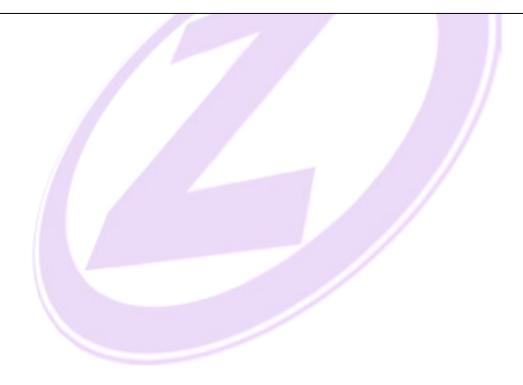
As of March 2018

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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 assessment/diagnostic 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.



As of March 2018

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PRE-AUTHORIZATION REQUEST Z BENEFITS FOR CHILDREN WITH HEARING IMPAIRMENT

in

DATE OF REQUEST (mm/dd/yyyy):

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

(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)

🛛 Со-рау

Certified correct by:	Certified correct by:				
(Printed name and signature) Attending Otolaryngologist	(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 APPLICA	ΓΙΟΝ		COMPLIANCE TO REQUIREMENTS			
Activity	Initial	Date	□ APPROVED			
Received by LHIO/BAS:			\Box DISAPPROVED (State reason/s)			
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			□ Approved □ Disapproved			
year from date of approval of request.			Released to HCI:			

As of March 2018

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