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 ☐ **Yes** 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 (✓) 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 ☐ Sensorineural hearing loss presenting with either moderate or severe to profound hearing loss (Tick one) ☐ Moderate hearing loss ☐ Severe - Profound hearing loss ☐ No signs and symptoms of an active ear infection	

Conforme by Patient/Parent/Guardian:

____
Printed name and signature

Attested by Attending Otolaryngologist

____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

teamphilhealth www.facebook.com/PhilHealth www.youtube.com/teamphilhealth actioncenter@philhealth.gov.ph

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.

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PRE-AUTHORIZATION REQUEST
Z BENEFITS FOR CHILDREN WITH HEARING IMPAIRMENT

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z benefit package for
_______________________________ in ______________________________
(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)
- ☐ Co-pay

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 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 HCI:			Received by BAS:		
This pre-authorization is valid for one (1) fiscal year from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		