Annex A.1: Pre-authorization Checklist and Request Form for Heart Valve Replacement for Valvular Heart Disease (Adult)

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER □ Same as above (Answer only if the patient is a dependent)	Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Pre-authorization Checklist and Request Form

Heart Valve Replacement for Valvular Heart Disease (Adult)

Place a (✔) or appropriate remarks

TYPE OF PROCEDURE*	Remarks
Mitral valve replacement with tricuspid valve annuloplasty	
Mitral valve replacement	
Aortic valve replacement	

*The contracted HF shall select one surgical procedure to be performed on the patient

Place a (✔) or appropriate remarks

General Criteria	Remarks
At least 19 years old	
EUROscore II and STS score <5% mortality	
Life expectancy of more than 5 years	
For patients aged 45 years old and above, no evidence of coronary artery disease based on coronary angiogram (Coronary angiogram should be within 1 year of procedure)	
No previous history of Valvular Surgery	
Not in decompensated heart failure New York Heart Association (NYHA) Classification IV	
No other concomitant surgeries (CABG, Permanent Pacemaker Insertion (PPI), aortic root repair) planned with valve surgery	
No active malignancies	
No liver cirrhosis	
No previous cardiac or thoracic surgery	

Place a (✔) on the appropriate procedure to be performed and remarks

☐ **Mitral Valve Replacement**	**Remarks**
Severe Mitral Stenosis a. Symptomatic NYHA II b. MVA <1.5 with Wilkins valve score of 9 or more)	
Severe Primary or Rheumatic Mitral Regurgitation a. Symptomatic NYHA II b. Left Ventricular End-Systolic Diameter (LVESD) >/=4cm c. Left ventricular ejection fraction (LVEF) >45%	

☐ **Mitral Valve Replacement with Tricuspid valve annuloplasty**	**Remarks**
Severe Mitral Stenosis with Tricuspid Regurgitation a. Symptomatic NYHA II b. MVA <1.5 with Wilkins valve score of 9 or more) c. With moderate to severe tricuspid regurgitation d. Dilated tricuspid valve (TV) annulus >/=4cm or index TV annulus >/=2.1	
Severe Primary or Rheumatic Mitral Regurgitation with Tricuspid Regurgitation a. Symptomatic NYHA II b. Left Ventricular End-Systolic Diameter (LVESD) >/=4cm c. Left ventricular ejection fraction (LVEF) >45% d. Moderate to severe tricuspid regurgitation e. Dilated tricuspid valve (TV) annulus >/=4cm or index TV annulus >/=2.1	

☐ **Aortic Valve Replacement**	**Remarks**
Severe Aortic Stenosis a. Any aortic stenosis presenting with symptoms of chest pain, syncope and shortness of breath, hypotension on stress testing, b. Asymptomatic with Aortic valve area of < 1.0 cm2 and gradient of >/= 40 mmHg	
Severe Aortic Regurgitation a. Symptomatic NYHA II with LVEF >55% b. Symptomatic NYHA II-III with LVEF of less than 55% but more than 25% c. Left ventricular end-systolic dimension of more than 5.0 cm with a stroke volume of more than 25mm/m2	

*The contracted HF shall select one surgical procedure to be performed on the patient

Certified correct by:	Conforme by:
(Printed name and signature) Attending Cardiologist or Cardiovascular Surgeon	(Printed name and signature) ☐ Patient ☐ Parent ☐ Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	

Note:
Once approved, the contracted HF 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 Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease.** Please do not leave any item blank.

PRE-AUTHORIZATION REQUEST

Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease (Adult)

DATE OF REQUEST (mm/dd/yyyy):
This is to request approval for provision of services under the **Z Benefits Package for Valvular Heart Disease Repair and/or Replacement** _____ in _____ (Patient's last, first, suffix, middle name) (Name of HF) under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on copayment and agreed to avail of the benefit package (please tick appropriate box): □ Without copayment □ With copayment, for the purpose of: _____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) □ Patient □ Parent □ Guardian	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
	PhilHealth Accreditation No.

(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) _____ (Printed name and signature) Head or authorized BAS representative		
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 the date of approval of request.			□ Approved □ Disapproved		
			Released to HF:		