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

Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

Case No. _____

Annex "A – KT"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (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
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

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

QUALIFICATIONS	YES
At least 10 years of age	
On chronic dialysis because of end stage renal disease except for pre-emptive kidney transplantation	

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURGEON

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

QUALIFICATIONS	YES
With irreversible renal disease that progresses to end stage renal disease.	
No previous history of cancer (except basal cell skin cancer).	
If patient is HIV-positive, the HIV-1 RNA viral load should be below detectable levels while on anti-retroviral therapy (<50 copies/mL) and CD4+ count should be >200 cells/mm^3; hepatitis B surface antigen negative; and hepatitis C antibody negative.	
Absence of current severe illness (congestive heart failure class 3-4), liver cirrhosis (findings of small liver with coarse granular/heterogeneous echo pattern with signs of portal hypertension), chronic lung disease requiring oxygen, etc.	

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

QUALIFICATIONS	YES
Absence of the following: hemiparalysis, leg amputation because of peripheral vascular disease, mental incapacity such that informed consent cannot be made, and substance abuse for at least 6 months prior to start of transplant work-up.	
For CMV IgG negative recipient, donor should be CMV IgG negative.	

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

DIAGNOSTICS	YES
For pre-emptive kidney transplant and diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 20 mL/min /1.73m^2	
For pre-emptive kidney transplant and non-diabetic: 24-hour urine creatinine clearance or calculated glomerular filtration rate (GFR) (CKD-EPI formula) or nuclear GFR should be less than 15 mL/min /1.73m^2	
Low risk: a. Primary kidney transplant (no previous solid organ transplant) b. Historical Past Panel Reactive Antibody (PRA) Class 1 & 2 negative c. If Historical Past Panel Reactive Antibody (PRA) Class 1 and/or 2 is positive, must fulfill the following: c.1 Historical PRA less than or equal to 20% c.2 No donor specific antibody (DSA) in the potential recipient d. Single organ transplant e. Negative tissue crossmatch	

Certified correct by Attending

Certified Correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

PhilHealth Accreditation No. | | | | | – | | | | | | | | – | |

Note:
Once approved, the contracted HCI 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
End Stage Renal Disease requiring Kidney Transplantation (Low Risk)

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 HCI)
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 (indicate amount) Php _____

Conforme by Patient/Parent/Guardian:	Certified correct by: (for Service Patients)
(Printed name and signature)	(Printed name and signature)
Certified correct by:	Please tick appropriate box ☐ Chair, Department of Adult Nephrology ☐ Chair, Dept. of Pediatric Nephrology ☐ Chair, Department of Organ Transplantation ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
(Printed name and signature) Attending Nephrologist	
PhilHealth Accreditation No.	PhilHealth Accreditation No.

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
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 HCI:		