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

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A – KT"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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)

ATTESTED BY ATTENDING NEPHROLOGIST or TRANSPLANT SURGEON

(Place ✓ if YES or NA if not applicable)

QUALIFICATIONS	YES
1. On chronic dialysis because of end stage renal disease except for pre-emptive kidney transplantation	
2. Anti-HCV negative	
3. 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.	
4. Absence of the following: hemiparalysis, mental incapacity such that informed consent cannot be made, and substance abuse for at least 6 months prior to start of transplant work-up.	
5. No previous history of cancer (except basal cell skin cancer).	
6. 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/mm3	

(Place ✓if YES or NA if not applicable)

QUALIFICATIONS	YES
7. If the patient is HbsAg positive, all the following conditions must be met: (If NA, write "NA" under 7a, b, c, and d, then proceed to Item No. 8.) a. absence of liver cirrhosis	
b. HBV- DNA <2,000 IU/ml	
c. cleared by a gastroenterologist, who is a member of the medical staff of the transplant facility Clearance by the gastroenterologist _____ Printed name and signature of gastroenterologist PhilHealth Accreditation No. _____	
d. The patient is informed that if there shall be additional cost of other interventions, these shall be sourced from other financing sources. I was informed that if there shall be additional cost of other interventions, these shall be sourced from other financing sources; and I understand that I will require antiviral prophylaxis for as long as it is indicated. Conformed by: _____ Printed name and signature ☐ patient ☐ parent ☐ guardian	
8. If the recipient is CMV IgG negative, any of the following should qualify: (If NA, write "NA" under 8a and b.) a. Donor should be CMV IgG negative; OR	
b. Recipient is CMV IgG negative and donor is CMV IgG positive: I understand that I will require CMV prophylaxis for as long as it is indicated and I am informed that I will be responsible for the additional cost of this medication and other interventions. Conformed by: _____ Printed name and signature ☐ patient ☐ parent ☐ guardian	

(Place ✓ if YES or NA if not applicable)

DIAGNOSTICS	
1. 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	☐ Yes ☐ NA
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	☐ Yes ☐ NA
3. Low risk: a. Primary kidney transplant (no previous solid organ transplant)	☐ Yes
b. Single organ transplant	☐ Yes
c. Negative tissue crossmatch	☐ Yes
d. Historical Panel Reactive Antibody (PRA) Class 1 & 2 negative	☐ Yes ☐ No. If "No", answer e.1 and e.2
e. If Historical Panel Reactive Antibody (PRA) Class 1 and/or 2 is positive, must fulfill the following:	
e.1 Historical PRA less than or equal to 20%	☐ Yes
e.2 No donor specific antibody (DSA) in the potential recipient	☐ Yes

Certified Correct by Attending Nephrologist or Transplant Surgeon:

_____

Printed name and signature

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

Note:
Once approved, the contracted *HCP* 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 _____
(Patient's *last, first, suffix, middle name*) (Name of *HCP*)

under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):

☐ *Without co-payment*
☐ *With co-payment, for the purpose of:* _____

Conforme by Patient/Parent/Guardian:	Certified correct by: (for Service Patients)
(Printed name and signature)	(Printed name and signature) 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
Certified correct by: (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 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 *HCP*:			Received by BAS:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HCP*:		