



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 **SEGUARADO**

Case No. _____

Annex "A – MORPH"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

Fulfilled selections criteria **Yes** If yes, proceed to pre-authorization application
 No If no, specify reason/s and encode

PRE-AUTHORIZATION CHECKLIST FOR Z MORPH
Fitting of External Lower Limb Prosthesis below the Knee

Place a check mark (✓) on the appropriate lower limb:
 Right lower limb Left lower limb Right & left lower limbs

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

	QUALIFICATIONS	Yes
1.	Age at least 15 years	
2.	At least 3 months post-amputation, if acquired	
3.	Wheelchair Independent -Community Ambulator With or without prosthesis	
	With or without cane or crutches or walker	
4.	No Co-morbidities:	
	a. No congestive heart failure or ischemic heart disease	
	b. No chronic obstructive or restrictive lung disease	
	c. No systemic infection	
5.	Physical Examination:	
	No fresh or non-healing wound	
	No neuroma or painful residual limb	
	No motor strength <4/5 of lower limbs	
	No limitation of motion of lower limbs	
	No incoordination or poor balance	

Conforme by Patient/Parent/Guardian:

Attested by Attending Rehabilitation
Medicine Specialist

Printed name and signature

Printed name and signature

PhilHealth
Accreditation No.

- -

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 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.





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



PRE-AUTHORIZATION REQUEST FOR Z MORPH
Fitting of External Lower Limb Prosthesis below the Knee

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 (indicate amount) Php _____

Certified correct by:

Certified correct by:

(Printed name and signature)
Attending Rehabilitation Medicine Specialist

(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)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	Initial	Date	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED (State reason/s)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved			Activity	Initial	Date
Released to HCI:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		
			Released to HCI:		