

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

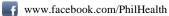


	e No	
	Annex "A – Mobility Ir	mpairment"
HE	EALTH CARE INSTITUTION (HCI)	
ΑΓ	DDRESS OF HCI	
PA	TIENT (Last name, First name, Middle name, Suffix)	
PH	ILHEALTH ID NUMBER OF PATIENT	
ME	EMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)	
PH	TILHEALTH ID NUMBER OF MEMBER	1 - \Box
Fu	Ifilled selections criteria	ation
	PRE-AUTHORIZATION CHECKLIST Z BENEFITS FOR CHILDREN WITH MOBILITY IMPAIRMEN Place General Qualifications	NT e a (✓) if yes Yes
1.	The child's chronological age is 0 to 17 years and 364 days old	ies
2.		
	The child does NOT have any condition that will compromise safety and functionality with the use of prosthesis, orthosis, wheelchair or seating device.	
3.	functionality with the use of prosthesis, orthosis, wheelchair or seating	
3.	functionality with the use of prosthesis, orthosis, wheelchair or seating device. On physical examination, the child has no fresh or non-healing wound on	
	functionality with the use of prosthesis, orthosis, wheelchair or seating device. On physical examination, the child has no fresh or non-healing wound on the body part of interest	

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General Qualifications (Cont.)	Yes
☐ Neuromuscular conditions characterized with any of the	
following: weakness or paralysis, imbalance, incoordination,	
sensory deficits classified into:	
☐ GMFCS 1 and 2 for prosthesis and orthosis	
☐ GMFCS 3, 4, and 5 for seating device, and wheelchair	
☐ Cardiopulmonary, behavioral or cognitive conditions that impairs a	
child's mobility	

Place a (✓) on the box for the a	appropriate assistive device that will be given	to the child:
	Shoulder disarticulation	Laterality
Upper Extremity	Above elbow	Right
Prosthesis	Below elbow	Left
(GMFCS 1, and 2)	Hand glove (2 or more fingers)	Both
	Finger (1 finger)	1
	Hip disarticulation	Laterality
Lower Extremity	Above knee or with knee	Right
Prosthesis	disarticulation	Left
(GMFCS 1, and 2)	Below knee or ankle disarticulation	Both
	Partial foot	
	Talipes Equinovarus (Club Foot)	Laterality
	Ankle foot orthosis (AFO)	Right
Orthosis	Knee ankle foot orthosis (KAFO)	Left
(GMFCS 1, and 2)	Hip knee ankle foot orthosis	Both
///	(HKAFO)	
	Spinal bracing / orthosis	
Seating Device	For ages 6 months to < 7 years old	
(GMFCS 3,4, and 5)	Seating device	
Wheelchair	For ages seven to 17 years and 364 da	ys old
(GMFCS 3,4, and 5)	Basic Wheelchair	
(GWI1*C5 5,4, and 5)	Intermediate Wheelchair	

Conforme by Patient/Parent/Guardian:	Attested by Rehabilitation Medicine Specialis		
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.

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PRE-AUTHORIZATION REQUEST Z BENEFITS FOR CHILDREN WITH MOBILITY 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 PATIE)		eed for a	(NAME OF HC availment of the Z Benefit Packa)	
under the terms and condition	iis as agi	.ccu 101 <i>a</i>	avaimment of the 22 Denem 1 acka	gc.		
The patient belongs to the fo	llowing	category	(please tick appropriate box):			
☐ No Balance Billing (NBB)					
□ Co-pay						
			0 (0.1			
Certified correct by:			Certified correct by:			
(Printed name and	0	,	(Printed name and signature)			
Attending Medical	Specialis	t	Executive Director/Ch		1	
PhilHealth		1	Medical Director/ Medi	ical Cente	r Chief	
Accreditation No.			Accreditation No.	S.		
			Conforme by:		/	
			(Printed name and signature)			
	/		Patient/Parent/	Guardian		
	(Fo	r PhilHe	alth Use Only)			
□ APPROVED	`					
☐ DISAPPROVED (State re	ason/s)					
(D.: 1 1 1 : .	``	_				
(Printed name and signatu Authorized Personnel, Benefit	,	istration	Section (BAS)			
radiofized refsoluter, benefit	.s / tdillill	nstration	occion (b/13)			
INITIAL APPLICA	ΓΙΟΝ		COMPLIANCE TO REQ	UIREME	ENTS	
Activity	Initial	Date	□ APPROVED			
Received by LHIO/BAS:			☐ DISAPPROVED (State reaso	n/s)		
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 hundred			☐ Approved ☐ Disapproved			
eighty (180) calendar days from date of approval of request.			Released to HCI:			
_	4.000.					

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