Case No. ___________________          Annex A – PD First

**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, HCI to specify reason/s and encode

**PRE-AUTHORIZATION CHECKLIST**

**PD First Z Benefits**

**(Place a ✓ if YES)**

**QUALIFICATIONS**

For pediatric patients, aged 0 to 18 years and 364 days, written informed consent from the parents or guardian is secured.

**Conforme by Patient/Parent/Guardian**

___________________________

Printed name and signature

**ATTESTED BY ATTENDING Nephrologist**

**(Place a ✓ if YES)**

**QUALIFICATIONS**

Diagnosed with end stage renal disease (ESRD) requiring renal replacement therapy, *except for acute kidney injury (e.g. leptospirosis)*

Has a permanent Tenckhoff peritoneal dialysis catheter properly placed in the abdominal cavity

Has completed PD initiation in *an accredited health care institution*

No longer uremic, with stable vital signs

Patient and/or a caregiver have adequate training to perform PD at home using MANUAL exchanges.

Absence of any disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen

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As of May 2016
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.
Case No. _______________________

PRE-AUTHORIZATION REQUEST
PD First Z Benefits

DATE OF REQUEST (mm/dd/yy):

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:
☐ Head, Peritoneal Dialysis Unit OR
☐ Chair, Dept. of Adult Nephrology OR
☐ Chair, Dept. of Pediatric Nephrology OR
☐ Chair, Dept. of Organ Transplantation OR
☐ Executive Director/Chief of Hospital/Medical Director/Medical Center Chief

Attending Nephrologist

PhilHealth Accreditation No. - - - -

(For PhilHealth Use Only)
☐ APPROVED
☐ DISAPPROVED (State reason/s) ____________________________________________

(Partly printed name and signature)
Head, Benefits Administration Section (BAS)

<table>
<thead>
<tr>
<th>INITIAL APPLICATION</th>
<th>COMPLIANCE TO REQUIREMENTS</th>
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<tbody>
<tr>
<td>Activity</td>
<td>Initial</td>
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<tr>
<td>Received by LHIO/BAS:</td>
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<tr>
<td>Endorsed to BAS (if received by LHIO):</td>
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<tr>
<td>☐ Approved ☐ Disapproved</td>
<td></td>
</tr>
<tr>
<td>Released to HCI:</td>
<td></td>
</tr>
</tbody>
</table>

This pre-authorization is valid for sixty (60) calendar days from date of approval of request.

☐ Approved ☐ Disapproved

Released to HCI: