# Annex A-1

## HEALTH CARE INSTITUTION (HCI)

### ADDRESS OF HCI

### PATIENT (Last name, First name, Middle name, Suffix)

### MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

### PHILHEALTH ID NUMBER OF MEMBER

| □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ | □ |

### PRE-AUTHORIZATION CHECKLIST

**Orthopedic Implants: Hip Arthroplasty**

(Place a ✓ opposite appropriate answer)

### SITE OF INJURY

- □ Left side
- □ Right side
- □ Both sides

### AGE

- □ Less than or equal to 65 years and 364 days
- □ Age more than or equal to 66 years

Conforme by Patient/Parent/Guardian: 

__________________________

Printed name and signature

### ATTESTED BY ATTENDING PHYSICIAN

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

### QUALIFICATIONS

- □ Ambulatory prior to injury
- □ Normal or with mild systemic disease or no functional limitation (ASA I & II)

### CLINICAL FEATURES

- □ Hip fracture presenting with avascular necrosis of the femoral head; or neglected fracture of the hip; or hip fracture with pre-existing cox-arthritis; or displaced hip fracture
- □ For avascular necrosis of the femoral head, necrosis should be classified as FICAT Stage III or IV
- □ Hip dysplasia
- □ Severe osteoarthritis
- □ Severe inflammatory joint disease affected by rheumatoid arthritis, gouty arthritis, psoriatic arthritis or ankylosing spondylitis

Attested by Attending Orthopedic Surgeon: 

__________________________

Printed name and signature

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**Note:** There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.

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PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Hip Arthroplasty

DATE OF REQUEST:

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)
☐ Fixed Co-pay (indicate amount) Php ____________________

Conforme by: Certified correct by:

(Printed name and signature) (Printed name and signature)
Patient/Parent/Guardian Attending Orthopedic Surgeon

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) __________________________________

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

<table>
<thead>
<tr>
<th>INITIAL APPLICATION</th>
<th>COMPLIANCE OF REQUIREMENTS</th>
</tr>
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<tbody>
<tr>
<td>Date received by Local Health Insurance Office (LHIO): __________</td>
<td>☐ APPROVED</td>
</tr>
<tr>
<td>Date endorsed to BAS: __________</td>
<td>☐ DISAPPROVED (State Reason/s)</td>
</tr>
<tr>
<td>Date (Approved/Disapproved): __________</td>
<td>Date endorsed to BAS: __________</td>
</tr>
<tr>
<td>Date endorsed to LHIO: __________</td>
<td>Date (Approved/Disapproved) __________</td>
</tr>
<tr>
<td>Date released to Hospital: __________</td>
<td>Date endorsed to LHIO: __________</td>
</tr>
<tr>
<td>Date released to Hospital: __________</td>
<td>Date released to Hospital: __________</td>
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</tbody>
</table>

This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.