Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Registry No. _____

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT

Prevention of *Complications of* Preterm Delivery

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Requirements	Please check
1. Checklist of Eligibility Criteria (Annex A)	
2. Checklist of Requirements for Reimbursement (Annex E.1 - Prevention of *Complications of* Preterm Delivery)	
3. Completed PhilHealth Claim Form (CF) 1 OR PhilHealth Benefit Eligibility Form (PBEF)	
4. *Completed CF-2*	
5. Checklist of Mandatory and Other Services (Annex *C.1* - Prevention of *Complications of* Preterm Delivery)	
6. *Copy of completed Z Satisfaction Questionnaire (Annex D)*	
7. *Copy of Coordinated Referral and Transfer Form (Annex H)*	
8. *Original or certified true copy (CTC) of the Statement of Account (SOA)*	
9. *Copy of World Health Organization (WHO) partograph (Annex I) for the assessment of labor for women in active labor (cervical dilatation >= 4cm), when applicable* ● The referring facility must stabilize the woman and initiate assessment of	

Requirements	Please check
labor, when applicable, using the WHO partograph (for women in active labor) to properly endorse conditions requiring immediate referral to a contracted HCI for appropriate management and care indicated in PhilHealth Circular No. *s22- 2014* revised *s25-2015* (Social Health Insurance Coverage and Benefits For Women About To Give Birth): a. Maternal age below 19 years old at the date of delivery; b. First pregnancy in patients with age 35 years and older at the date of delivery; c. Multiple or multifetal pregnancy such as twins and triplets; d. Ovarian abnormality (e.g. ovarian cyst); e. Uterine abnormality (e.g. myoma uteri); f. Placental abnormality (e.g. placenta previa); g. Abnormal fetal presentation (e.g. breech); h. History of three (3) or more miscarriages/abortion; i. History of one (1) stillbirth; j· History of major obstetric and/or gynecologic operation (e.g. cesarean section, uterine myomectomy); k. History of medical conditions (e.g. hypertension, preeclampsia, eclampsia, heart disease, diabetes, thyroid disorder, morbid obesity, moderate to severe asthma, epilepsy, renal disease, bleeding disorder); I. Other risk factors that may arise during present pregnancy (e.g. premature contractions, vaginal bleeding) that warrant referral for further management. ● *The partograph is not required in* conditions wherein labor and vaginal delivery are contraindicated and immediate CS is indicated such as: obstructed labor due to severely deformed pelvis; uncontrolled hypertension, severe preeclampsia or eclampsia; profuse antepartum hemorrhage (including placenta previa, uterine rupture, or abruptio placenta); malpresentation (including breech, transverse, oblique, or brow), or fetal compromise (including fetal distress, cord prolapse, or severe intrauterine growth restriction). ● *The partograph is also not required when the newborn was delivered outside a health facility and not likely to have been attended by a health care worker.*	
DATE COMPLETED (mm/dd/yyyy):	
DATE FILED (mm/dd/yyyy):	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Physician	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No. _____ – _____ – _____	Date signed (mm/dd/yyyy)
Date signed (mm/dd/yyyy)	