Case No. _______________

Annex A – "Prostate CA"

HEALTH CARE PROVIDER (HCP)		
ADDRESS OF HCP		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ Same as patient (Answer the following only if the patient is a dependent) 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

PRE-AUTHORIZATION CHECKLIST
Prostate Cancer

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

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES)

QUALIFICATIONS	YES
No previous radiotherapy for prostate cancer	
No uncontrolled co-morbid conditions	

(Place a ✓if YES)

DIAGNOSTICS	YES	DATE DONE (mm/dd/yyyy)
(T1a-T3c), Tumor Grade (Gleason's score of 6-9)		
No evidence of metastasis (documented by any of the following): ☐ Bone scan ☐ Pelvic CT/MRI ☐ PET Scan (Attach results to the patient's chart)		

Conforme by Patient/Guardian:

____
Printed name and signature

Certified correct by Attending Physician:

____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

Note:
Once approved, the contracted HCP shall print the approved pre-authorization form and have this signed by the patient 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) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

PRE-AUTHORIZATION REQUEST
Prostate Cancer

DATE OF REQUEST (mm/dd/yyyy):
This is to request approval for provision of services under the Z benefit package for ______________________ in ______________________ (Patient's last, first, suffix, middle name) (Name of HCP) under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box): ☐ Without co-payment ☐ With co-payment, for the purpose of: ______________________

Certified correct by:	Certified correct by:
(Printed name and signature) Attending *Physician*	(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

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) ______________________

____
(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

INITIAL APPLICATION			**COMPLIANCE TO REQUIREMENTS**		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s) ______________________ (Printed name and signature) Head or authorized BAS representative		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to HCP:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCP:		