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

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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

PRE-AUTHORIZATION CHECKLIST
Rectal Cancer
Stages I to III (clinically *T1-T4*, N0-2, M0)

Place a check mark (✓)

QUALIFICATIONS	**Yes**
Biopsy proven tissue diagnosis of rectal cancer	
No evidence of systemic metastasis from chest x-ray and abdominal ultrasound or CT scan of whole abdomen	
No previous pelvic radiation	

SITE OF CANCER (check applicable site)
☐ cecum ☐ ascending colon ☐ hepatic flexure ☐ transverse colon
☐ splenic flexure ☐ descending colon ☐ sigmoid
☐ for synchronous tumor, specify sites _____

CLINICAL STAGE (Choose one stage)
☐ Stage I ☐ Stage II ☐ Stage III

OTHER QUALIFICATIONS	**Yes**
1. Normal or with mild systemic disease (ASA I or II)	
2. Fully active, able to carry on all pre-disease performance without restriction, OR restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work, OR ambulatory and *capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.* (ECOG Performances 0-2)	

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Certified correct by Attending Surgeon:

Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐–☐☐☐☐☐☐–☐

Certified correct by Attending Medical Oncologist:

Printed name and signature
PhilHealth Accreditation No.
☐☐☐☐–☐☐☐☐☐☐–☐

Conforme by Patient:

Printed name and signature

Note:
Once approved, the contracted *HF* shall print the approved pre-authorization form from the HCI Portal 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
Rectal 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 *HF*) 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 Surgeon	(Printed name and signature) Attending Medical Oncologist
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) Patient	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
	PhilHealth Accreditation No.

(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)		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to *HF*:			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to *HF*:		