

RRepublic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City Call Center (02) 441-7442 Trunkline (02) 441-7444 www.philhealth.gov.ph



Case No		
	Annex A – "R	ectum CA"
HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
PATIENT (Last name, First name, Middle name, St	uffix)	
PHILHEALTH ID NUMBER OF PATIENT	D-	
MEMBER (if patient is a dependent) (Last name, First	name, Middle name, Suffix)	
PHILHEALTH ID NUMBER OF MEMBER	D-	
Fulfilled selections criteria	ed to pre-authorization application to specify reason/s and encode	
PRE-AUTHORIZATION Rectum Can Stages I to III (clinically	ancer 7 T1-4, N0-2, M0)	eck mark (✔)
QUALIFICATIONS		Yes
Biopsy proven tissue diagnosis of rectal cancer No evidence of systemic metastasis from chest x-ray CT scan of whole abdomen No previous pelvic radiation	y and abdominal ultrasound or	
CLINICAL STAGE (Choose one stage) ☐ Stage I ☐ Stage II ☐ Stage I	III	
OTHER QUALIFICATIONS		Yes
 Normal or with mild systemic disease (ASA Fully active, able to carry on all pre-restriction, OR restricted in physically streand able to carry out work of a light or sec work, office work, OR ambulatory and caperformances 0-2) 	disease performance without enuous activity but ambulatory dentary nature, e.g. light house	
Certified correct by Attending Surgeon:	Certified correct by Attending M. Oncologist:	Iedical
Printed name and signature PhilHealth Accreditation No.	Printed name and signa PhilHealth Accreditation No.	ature

As of September 2015

Page 1 of 3 of Annex A – Rectum CA

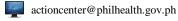
Certified correct by Attending Radiation Oncologist:	Conforme by:
Printed name and signature	Printed name and signature
PhilHealth Accreditation No.	

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.







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PRE-AUTHORIZATION REQUEST **Rectum Cancer**

DATE OF REQUEST (mm/dd/yyyy):										
This is to request approval for provision of			nder the Z be	nefit p	oackag	e for				
(NAME OF PATIENT) under the terms and conditions as agreed		in _	(NAM nt of the Z Be							
The patient belongs to the following category ☐ No Balance Billing (NBB) ☐ Co-pay (indicate amount) Php	gory (p	lease	tick appropria	te box	x):					
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.			Į,				-
Certified correct by:	y		Certified correct by:							
(Printed name and signature) Radiation Oncologist			(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief							
PhilHealth Accreditation No.		_	PhilHealth Accreditation No.	7/					-	-
			Conforme by: (Printed name and signature) Patient							
(For PhilHealth Use Only) □ APPROVED □ DISAPPROVED (State reason/s)										
Noted by:										
(Printed name and signature) Head, Benefits Administration Section (BAS)										
INITIAL APPLICATION			COMPLIANC	ЕТО	REQ	UIR	EM.	ENT	TS .]
Activity Initial I Received by LHIO/BAS: Endorsed to BAS (if received by LHIO):	Date		APPROVED DISAPPROVEI) (State	e reaso	on/s)				
☐ Approved ☐ Disapproved			Activity			Ini	itial]	Date	
Released to HCI:		Rece	ived by BAS:							
This pre-authorization is valid for sixty (60)			pproved Di	sappro	oved					
calendar days from date of approval of request.		Relea	ised to HCI:							1

As of September 2015

Page 3 of 3 of Annex A – Rectum CA





