## Annex A.5: Pre authorization Checklist and Request for Total Knee Replacement

Revised as of March 2023



## Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION Citystate Centre, 709 Shaw Boulevard, Pasig City (02) 8441-7442 ⊕www.philhealth.gov.ph PhilHealthOfficial ▼ teamphilhealth

Case No	Case No								
HEALTH FAC	CILITY (HF)								
ADDRESS OF	FHF								
A. PATIENT	A. PATIENT 1. Last Name, First Name, Middle Name, Suffix SE								
	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 -	-						
Fulfilled selections criteria  Yes If yes, proceed to pre-authorization application  No If no, HF to specify reason/s and encode									
PRE-AUTHORIZATION CHECKLIST  Orthopedic Implants: Total Knee Replacement  (Place a ✓ opposite appropriate answer)									
SITE OF INJU	J <b>RY</b>	Left side Right side Both sides							
SURGICAL URGENCY  Emergency: Date of surgery (mm/dd/yyyy):  Elective									
ATTESTED BY ATTENDING PHYSICIAN  (Place a ✓if YES, or NA if not applicable)									
QUALIFICA'	Yes								
Ambulatory pri	or to injury								
		disease or no functional limitation (ASA I & II)							
		ee (2 to 3) co-morbid illnesses based on physical							
status classifica	tion based on A	SA (low to moderate risk)							
CLINICALE	EATHDEC		Vas						
Disabling base to	Yes								
0 1		radiographic findings; Arthritis consists of articular ty that can result from the following: (tick appropriate							
cartilage, bony changes, and deformity that can result from the following: (tick appropriate description)									
☐ Idiopathic osteoarthritis									
□ Post-traumatic osteoarthritis									
☐ Avascular necrosis (idiopathic or secondary)									
☐ Inflammat spondylitis,									
☐ Isolated se									

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

### Note:

Once approved, the contracted HF 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 Orthopedic Implants: Total Knee Replacement

DATE OF REQUEST (mm/dd/yyyy)::										
This is to request approval for provision of services under the Z Benefits package for										
in										
(NAME OF PATIENT) (NAME OF HF)										
under the terms and conditions as agreed for availment of the Z Benefits Package.										
The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):  Without co-payment  With co-payment, for the purpose of:										
			Certified correct by:							
Conforme by:			certained correct by.							
(Printed name and signature)			(Printed name and signature)							
Patient/Parent/Guardian			Attending Orthopedic Surgeon							
			PhilHealth Accreditation No.							
		Certified correct by:								
		(Printed name and signature)								
		Executive Director/Chief of Hospital/								
		Medical Director/ Medical Center Chief								
		PhilHealth								
		Accreditation No.	Accreditation No.							
	(For	DhilHool	th Use Only)							
☐ APPROVED	(1.01	1 IIIII I Cai	tui Ose Omy)							
☐ DISAPPROVED (State re	ason/s)									
(Printed name and signatus	re)									
Head or authorized representative, Benefits Administration Section (BAS)										
INITIAL APPLICA		COMPLIANCE TO REQUIREMENTS								
Activity	Initial	Date	☐ APPROVED							
Received by LHIO/BAS:			☐ DISAPPROVED (State reason/s)							
Endorsed to BAS (if received by LHIO):										
☐ Approved ☐ Disapproved			Activity	Initial	Date					
Released to HF:			Received by BAS:							
This pre-authorization is valid:	60)	☐ Approved								
calendar days from date of appr		□ Disapproved								
, Tr			Released to HF:							