



*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**

Citystate Centre Building, 709 Shaw Boulevard, Pasig City  
Healthline 441-7444 [www.philhealth.gov.ph](http://www.philhealth.gov.ph)



Bawat Pilipino **MIYEMBRO**  
Bawat miyembro **PROTEKTADO**  
Kalusugan natin **SEGURADO**

Case No. \_\_\_\_\_

**Annex A4 –Ortho Implants**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
MEMBER ( <i>if patient is a dependent</i> ) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>

<p><b>Fulfilled selections criteria</b> <input type="checkbox"/> <b>Yes</b> <i>If yes, proceed to pre-authorization application</i>  <input type="checkbox"/> <b>No</b> <i>If no, HCI to specify reason/s and encode</i></p> <p align="center">_____</p>
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**PRE-AUTHORIZATION CHECKLIST**  
**Orthopedic Implants: Femoral and Tibial Shaft Fractures**

(Place a ✓ opposite appropriate answer)

<b>SITE OF INJURY</b>	<input type="checkbox"/> Left side	<input type="checkbox"/> Right side	<input type="checkbox"/> Both sides
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**ATTESTED BY ATTENDING PHYSICIAN**

(Place a ✓ if YES, or NA if not applicable)

<b>QUALIFICATIONS</b>	<b>Yes</b>
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	

<b>CLINICAL FEATURES</b>	<b>Yes</b>
Femoral shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the femur	
Tibial shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the tibia	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/>
	Date signed (mm/dd/yyyy)



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**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**  
**Orthopedic Implants: Femoral and Tibial Shaft Fractures**

DATE OF REQUEST: \_\_\_\_\_

This is to request approval for provision of services under the Z benefit package for \_\_\_\_\_ in \_\_\_\_\_  
 (NAME OF PATIENT) (NAME OF HCI)  
 under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

<i>Billing category: (tick appropriate box)</i> <input type="checkbox"/> No Balance Billing (NBB) <input type="checkbox"/> Co-pay (indicate amount) Php _____	<i>Type of implant being applied for:</i> <input type="checkbox"/> Intramedullary nail with interlocking screws <input type="checkbox"/> Locked compression plate- broad, metaphyseal, proximal and distal: <input type="checkbox"/> femoral <input type="checkbox"/> tibial
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Conforme by:  (Printed name and signature) Patient/Parent/Guardian	Certified correct by:  (Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. _____ Date signed (mm/dd/yyyy)

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

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 (For PhilHealth Use Only)

- APPROVED  
 DISAPPROVED (State reason/s) \_\_\_\_\_

\_\_\_\_\_  
 (Printed name and signature)  
 Head, Benefits Administration Section (BAS)

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	Initial	Date			
Received by LHIO/BAS:			<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED (State reason/s)		
Endorsed to BAS (if received by LHIO):					
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved			Activity	Initial	Date
Released to HCI:			Received by BAS:		
<b>This pre-authorization is valid for sixty (60) calendar days from date of approval of request.</b>			<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		
			Released to HCI:		