Case No. _____

Annex A1–Ortho Implants

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

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

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Hip Arthroplasty

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides

ATTESTED BY ATTENDING PHYSICIAN

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

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

CLINICAL FEATURES	**Yes**
Hip fracture: (tick appropriate description): ☐ with avascular necrosis of the femoral head ☐ Neglected fracture of the hip ☐ Hip fracture with pre-existing cox-arthritis ☐ Displaced hip fracture	
With avascular necrosis of the femoral head (FICAT Stage III and IV)	
Hip dysplasia (CROWNE I-IV)	
Severe osteoarthritis	
Severe inflammatory joint disease (rheumatoid, gout, psoriatic, ankylosing, spondylitis)	

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. | | | | | – | | | | | | | – | | Date signed (mm/dd/yyyy)

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.

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Hip Arthroplasty

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):

Billing category: (tick appropriate box)	*Type of implant being applied for:*
☐ No Balance Billing (NBB)	☐ *Total hip prosthesis (cemented)*
☐ Co-pay (indicate amount) Php _____	☐ *Total hip prosthesis (cementless)*
	☐ *Partial hip prosthesis (bipolar)*

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. ____-____-____ 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. ____-____-____

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