

Case No.

Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION

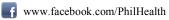
Citystate Centre Building, 709 Shaw Boulevard, Pasig City Healthline 441-7444 www.philhealth.gov.ph

	Annex A1	-Ortho Implants				
HEALTH CARE INSTITUTION (HCI)						
ADDRESS OF HCI						
PATIENT (Last name, First n	PATIENT (Last name, First name, Middle name, Suffix)					
PHILHEALTH ID NUMBEI	R OF PATIENT	<u> </u>				
MEMBER (if patient is a depende	ent) (Last name, First name, Middle name, Suffix)					
PHILHEALTH ID NUMBEI	R OF MEMBER	<u> </u>				
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 ATTEND	ING PHYSICIAN					
	(Place a ✓if YES, or NA if	not applicable)				
QUALIFICATIONS	(Place a ✓if YES, or NA if	not applicable) Yes				
Ambulatory prior to injury	(Place a ✓if YES, or NA if disease or no functional limitation (ASA I & II)	** ′				
Ambulatory prior to injury						
Ambulatory prior to injury Normal or with mild systemic	disease or no functional limitation (ASA I & II)	Yes				
Ambulatory prior to injury Normal or with mild systemic CLINICAL FEATURES Hip fracture: (tick appropriat with avascular necr	disease or no functional limitation (ASA I & II) e description): rosis of the femoral head	Yes				
Ambulatory prior to injury Normal or with mild systemic CLINICAL FEATURES Hip fracture: (tick appropriat with avascular necr Neglected fracture	disease or no functional limitation (ASA I & II) e description): rosis of the femoral head of the hip	Yes				
Ambulatory prior to injury Normal or with mild systemic CLINICAL FEATURES Hip fracture: (tick appropriat with avascular necr Neglected fracture Hip fracture with p	disease or no functional limitation (ASA I & II) e description): rosis of the femoral head of the hip ore-existing cox-arthritis	Yes				
Ambulatory prior to injury Normal or with mild systemic CLINICAL FEATURES Hip fracture: (tick appropriat with avascular necr Neglected fracture Hip fracture with p Displaced hip fract	disease or no functional limitation (ASA I & II) e description): rosis of the femoral head of the hip ore-existing cox-arthritis ure	Yes				
Ambulatory prior to injury Normal or with mild systemic CLINICAL FEATURES Hip fracture: (tick appropriat with avascular necro Neglected fracture Hip fracture with p Displaced hip fract With avascular necrosis of th	disease or no functional limitation (ASA I & II) e description): rosis of the femoral head of the hip ore-existing cox-arthritis ure e femoral head (FICAT Stage III and IV)	Yes				
Ambulatory prior to injury Normal or with mild systemic CLINICAL FEATURES Hip fracture: (tick appropriat with avascular necr Neglected fracture Hip fracture with p Displaced hip fract	disease or no functional limitation (ASA I & II) e description): rosis of the femoral head of the hip ore-existing cox-arthritis ure e femoral head (FICAT Stage III and IV)	Yes				
Ambulatory prior to injury Normal or with mild systemic CLINICAL FEATURES Hip fracture: (tick appropriat with avascular necro Neglected fracture Hip fracture with p Displaced hip fract With avascular necrosis of th Hip dysplasia (CROWNE I-I Severe osteoarthritis	disease or no functional limitation (ASA I & II) e description): rosis of the femoral head of the hip ore-existing cox-arthritis ure e femoral head (FICAT Stage III and IV)	Yes				

As of June 2016











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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 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: 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):							
☐ No Balance Billing (NBB) ☐ Co-pay (indicate amount) Php			Type of implant being applied for: □ Total hip prosthesis (cemented) □ Total hip prosthesis (cementless) □ Partial hip prosthesis (bipolar)				
Conforme by:			Certified correct by:				
(Printed name and sig Patient/Parent/Gua Date signed (mm/dd/yyyy)	,	I	(Printed name and signature) Attending Orthopedic Surgeon PhilHealth Accreditation No. - - Date signed (mm/dd/yyyy)				
			(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 Received by LHIO/ <i>BAS</i> : Endorsed to BAS (if received by LHIO):	Initial	Date	□ APPROVED □ DISAPPROVED (State reason/s)				
☐ 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:				

As of June 2016





