Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Case No. ______________

Annex A2 –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 Fixation

(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) ☐ Without avascular necrosis of the femoral head ☐ Acute fracture of the hip ☐ Displaced hip fracture	

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)

teamphilhealth www.facebook.com/PhilHealth www.youtube.com/teamphilhealth actioncenter@philhealth.gov.ph

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 Fixation

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 ________________

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:		