Case No. _____

Annex A3 –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: Pertrochanteric Fractures

(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**
Stable fracture of the intertrochanteric area, classified as Type A1 fracture	
Unstable/comminuted pertrochanteric fracture classified as Type A2 or A3 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)

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: Pertrochanteric Fractures

DATE OF REQUEST:
This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (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) ☐ No Balance Billing (NBB) ☐ Co-pay (indicate amount) Php _____	*Type of implant being applied for:* ☐ *Compression hip screw set* ☐ *Proximal femoral locked plate* ☐ *Proximal femoral nail*

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:		