



Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 441-7442 | Trunkline: (02) 441-7444
www.philhealth.gov.ph



PhilHealth@24:
Tungo sa Kalusugan
Para sa Lahat

Case No. _____

Annex "A1 – VSD"

HEALTH CARE INSTITUTION (HCI)		
ADDRESS OF HCI		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
	2. PhilHealth ID Number	<input type="text"/> - <input type="text"/> - <input type="text"/>
B. MEMBER <i>(answer only if patient is a dependent)</i>	1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number	<input type="text"/> - <input type="text"/> - <input type="text"/>

PRE-AUTHORIZATION CHECKLIST
Ventricular Septal Defect (VSD) Closure

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

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓) and indicate the date when the diagnostic procedure is done

DIAGNOSTICS ¹	YES	DATE DONE (mm/dd/yy)
Based on 2D Echocardiogram: ²		
a. Confirmed ventricular septal defect perimembranous, subaortic, subpulmonic, <i>or inlet type</i>		
b. NO combined shunts such as atrial septal defect or atrioventricular septal defect		
c. <i>Pulmonary artery maximum systolic pressure gradient <55 mmHg or pulmonary valve annulus with a Z score of -1 to +1</i>		
d. NO other associated congenital heart disease (CHD) : such as coarctation of the aorta, or moderate to severe aortic insufficiency		
e. Pulmonary arterial pressure (PAP) normal, mild to moderate or at least 2/3 the systolic blood pressure, confirmed by hemodynamic studies, if applicable		

¹ Must be done at least within six (6) months from date of receipt of pre-authorization

² Attach OFFICIAL 2D ECHO RESULTS in the patient's chart

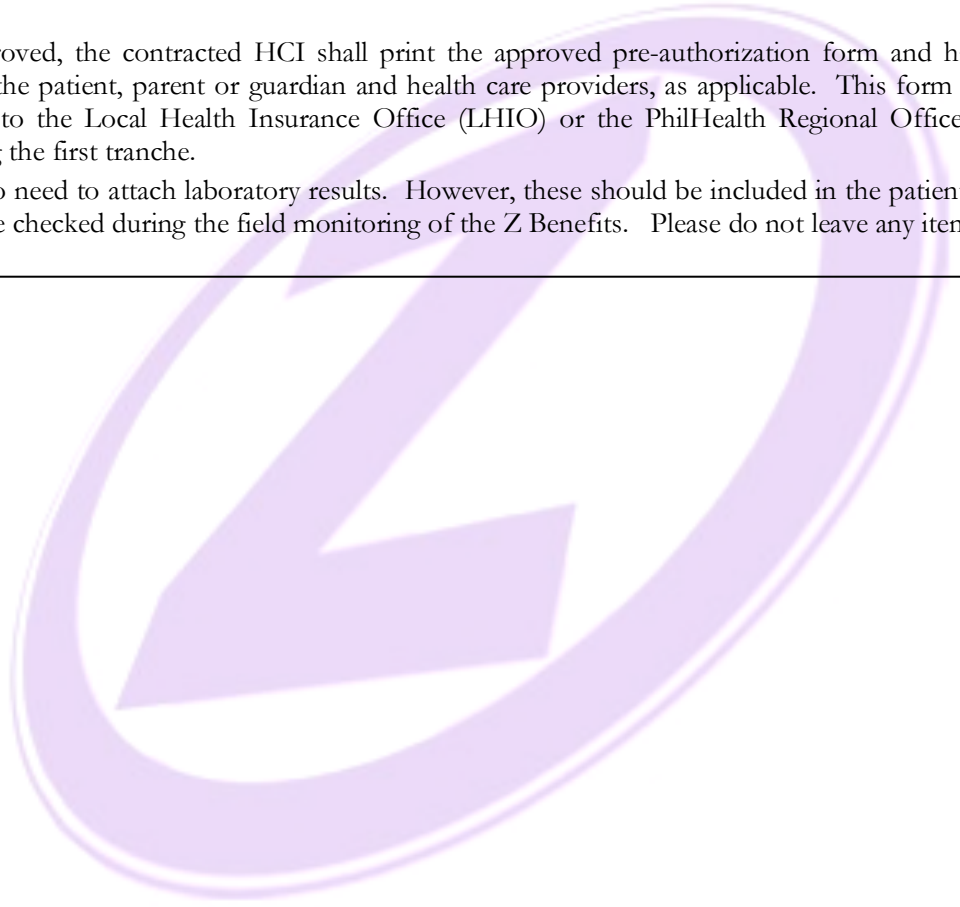


Certified correct by:				Conforme by:			
(Printed name and signature) Attending Pediatric Cardiologist				(Printed name and signature) Parent/Guardian			
PhilHealth Accreditation No.							
				-			-

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
Ventricular Septal Defect (VSD) Closure**

DATE OF REQUEST (mm/dd/yyyy)
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): <input type="checkbox"/> No Balance Billing (NBB) <input type="checkbox"/> Co-pay
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Certified correct by:	Certified correct by:
(Printed name and signature)	(Printed name and signature)
Please tick appropriate box <input type="checkbox"/> Chair, Department of Pediatric Cardiology <input type="checkbox"/> Chief, Division of Pediatric CV Surgery	Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:
(Printed name and signature) Patient

(For PhilHealth Use Only)

APPROVED
 DISAPPROVED (State reason/s) _____

(Printed name and signature)
Authorized Personnel, 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:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.			<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		
			Released to HCI:		

