Case No. _____

Annex "A2 – VSD"

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

PRE-AUTHORIZATION CHECKLIST
Ventricular Septal Defect (VSD) Closure with Associated Special Clinical Conditions

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 (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yy)
Based on 2D Echocardiogram:[2]		
a. Confirmed ventricular septal defect perimembranous, subaortic or subpulmonic		
b. **NO** combined shunts such as atrial septal defect or patent ductus arteriosus or atrioventricular septal defect		
c. **NO** other associated congenital heart disease (CHD) : such as coarctation of the aorta		
d. Mild to moderate pulmonic stenosis or aortic insufficiency		
e. Moderate to severe Pulmonary arterial hypertension with reactive pulmonary bed by cardiac catheterization		
f. Down's Syndrome with stable congenital associated defects		

[1] Must be done at least within six (6) months from date of application
[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.

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

Bawat Pilipino MIYEMBRO
Bawat miyembro PROTEKTADO
Kalusugan natin SEGURADO

PRE-AUTHORIZATION REQUEST
Ventricular Septal Defect (VSD) Closure with Associated Special Clinical Conditions

DATE OF REQUEST (mm/dd/yyyy)
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):

☐ No Balance Billing (NBB)
☐ Co-pay (indicate amount) Php _____

Certified correct by:	Certified correct by:
(Printed name and signature) Please tick appropriate box ☐ Chair, Department of Pediatric Cardiology ☐ Chief, Division of Pediatric CV Surgery	(Printed name and signature) 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)
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 one hundred eighty (180) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		