

## 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



HE	EALTH CARE INSTITUTION (HCI)	
AD	DDRESS OF HCI	
PA	TIENT (Last name, First name, Middle name, Suffix)	
РН	ILHEALTH ID NUMBER OF PATIENT	
ME	EMBER (answer only if patient is a dependent) (Last name, First name, Middle	name, Suffix)
DII	THE ALTH ID AND OF ACADED	
PH	ILHEALTH ID NUMBER OF MEMBER	
Fı	ulfilled selections criteria	ication
	PRE-AUTHORIZATION CHECKLIST	
	Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIE	ES
	Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIES  Place a (✓) in the status column if yes or NA if n	
	Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIES  Place a ( ) in the status column if yes or NA if n  General Qualifications	
1.	Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIES  Place a (✓) in the status column if yes or NA if n	ot applicable
	Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITION  Place a (✓) in the status column if yes or NA if n  General Qualifications  The child's chronological age is 0 to 17 years and 364 days old (required for all)  The child must have undergone a visual disabilities assessment from an	ot applicable
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#### Note:

Once approved, the contracted hospital 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 assessment/diagnostic 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 Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIES

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 HOSPITAL)								
		ed for ax						
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								
Certified correct by:			Certified correct by:					
(Printed name an	nd signature)	-	(Printed name and signature)					
Attending Opht	,		Executive Director/Chief of Hospital/					
True spine	8101		Medical Director/ Medical Center Chief					
PhilHealth			PhilHealth					
Accreditation No.			Accreditation No.					
		Conforme by:						
		Comornie by.						
			(Printed name and signature)					
			Patient/Parent/Guardian					
(For PhilHealth Use Only)								
□ APPROVED								
☐ DISAPPROVED (State reason/s)								
<u> </u>								
(Printed name and signature)								
Authorized Personnel, Benefits Administration Section (BAS)								
INITIAL APPLI	CATION		COMPLIANCE TO REQUIREMENTS					
Activity	Initial	Date	□ APPROVED					
Received by LHIO/BAS:			☐ DISAPPROVED (State reaso	on/s)				
Endorsed to BAS (if received LHIO):	by							
☐ Approved ☐ Disapprove	d		Activity	Initial	Date			
Released to HCI:			Received by BAS:					
This pre-authorization is val			☐ Approved ☐ Disapproved					
eighty (180) calendar days fro of request.	om date of ap	provai	Released to HCI:					

As of March 2018

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