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

Case No. _____

Annex "A1 –EMORPH"

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, specify reason/s and encode
_____

PRE-AUTHORIZATION CHECKLIST FOR EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

Place a (✓) if yes or NA if not applicable

QUALIFICATIONS	
a. Age ≥ 18 years old	
b. At least three months post-amputation, if acquired	
c. Wheelchair independent, community-ambulator with or without crutches, cane or walker	
d. On physical examination: no fresh or non-healing wound, neuroma or painful residual limb, no motor strength of <4/5 and limitation of motion of upper and/or lower limbs, no incoordination or poor balance	

Place a check mark (✓) on the type of prostheses to be given to the patient:

Z Benefits*	**Right**	**Left**	**Both**
I. Lower limb			
A. Above knee/ knee disarticulation			
B. Hip disarticulation			
C. Van Ness Rotationplasty			
II. Upper limb			
A. Below elbow			
B. Above elbow			

* For cases involving more than one amputations, the patient cannot claim for two prostheses with the same laterality in either the same limb.

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Attested by Attending Rehabilitation Medicine Specialist

_____
Printed name and signature

PhilHealth Accreditation No. ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐

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 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 FOR EXPANDED ZMORPH
Upper and Lower Limb Prosthesis

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 HOSPITAL)
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 _____

*NBB is applicable to sponsored members, indigent, kasambahay, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Rehabilitation Medicine Specialist	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.

(Printed name and signature)
Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to HCI:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		