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 "A2 – 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
Lower Limb Orthosis

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

	GENERAL QUALIFICATIONS	Yes
1.	Age ≥ 18 years old	
2.	At least 3 months post-onset	
3.	Upper limbs ≥ 4 with fair trunk control and full range of motion, if bilateral	
4.	Unaffected limbs ≥ 3 with fair trunk control and full range of motion, if unilateral	
5.	Ambulatory with assistive device	
6.	No fresh or non-healing wound	

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

	QUALIFICATIONS SPECIFIC TO ANKLE FOOT ORTHOSIS	Yes
1.	Weakness or absence of dorsiflexors &/or plantarflexors, +/- grade 1-2 spasticity with full range of motion achieved passively	
2.	Equinovarus +/- foot rotation and +/- grade 1-2 spasticity with full range of motion achieved passively	
3.	Pain & Instability secondary to sensory or structural deficit in a Charcot Arthropathy	

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

QUALIFICATIONS SPECIFIC TO KNEE ANKLE FOOT ORTHOSIS	Yes
Quadriceps MMT of <3 +/- sensory loss ,+/- instability (genu recurvatum) with hip/knee flexion contracture <20 degrees	

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

QUALIFICATIONS SPECIFIC TO HIP KNEE ANKLE FOOT ORTHOSIS	Yes
Hip, knee, ankle & foot muscles MMT <3 +/- sensory loss, +/- instability, with hip /knee flexion contracture <20 degrees	

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

Z Benefits	Right	Left	Both
Ankle Foot Orthosis			
Knee Ankle Foot Orthosis			
Hip Knee Ankle Foot Orthosis			

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 ZMORPH
Lower Limb Orthosis

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. [ ][ ][ ][ ] – [ ][ ][ ][ ][ ][ ][ ] – [ ]

Conforme by:
(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			**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:		

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