

Republic of the Philippines PHILIPPINE HEALTH INSURANCE CORPORATION Citystate Centre Building, 709 Shaw Boulevard, Pasig City

Citystate Centre Building, 709 Shaw Boulevard, Pasig City Healthline 441-7444 <u>www.philhealth.gov.ph</u>



Annex A-3

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALT'H ID NUMBER OF MEMBER

PRE-AUTHORIZATION CHECKLIST Orthopedic Implants: Pertrochanteric Fractures

	(Place a ✓ opposite appropriate answer)
SITE OF INJURY	Left side Right side Both sides

Conforme by Patient/Parent/Guardian:

ATTESTED BY ATTENDING PHYSICIAN

Printed name and signature

(Place a ✓ if YES, or NA if not applicable)

QUALIFICATIONS	Yes
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	

CLINICAL FEATURES	Yes
Stable fracture of the intertrochanteric area, classified as Type A1 fracture	
Unstable/comminuted pertrochanteric fracture classified as Type A2 or A3	
fracture	

Attested by Attending Orthopedic Surgeon:

Printed name and signature

Note: There is no need to attach laboratory results. These may be checked during monitoring and post-audit. Do not leave any items blank.



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PRE-AUTHORIZATION REQUEST Orthopedic Implants: Pertrochanteric Fractures

DATE OF REQUEST:

This is to request approval for provision of services under the Z benefit package for

(NAME OF PATIENT)

_ in _

(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)

□ Fixed Co-pay (indicate amount) Php ____

Conforme by:	Certified correct by:
(Printed name and signature)	(Printed name and signature)
Patient/Parent/Guardian	Attending Orthopedic Surgeon
	Certified correct by:
	$\langle \mathbf{D} : \mathbf{A} 1 = 1 : \mathbf{A} \rangle$
	(Printed name and signature)
	Executive Director/Chief of Hospital

(For PhilHealth Use Only)

□ APPROVED

□ DISAPPROVED (State reason/s) _____

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

INITIAL APPLICATION	COMPLIANCE OF REQUIREMENTS
Date received by Local Health Insurance	□ APPROVED
Office (LHIO:	□ DISAPPROVED (State Reason/s)
Date endorsed to BAS:	
Date (Approved/Disapproved): Date endorsed to LHIO: Date released to Hospital:	Date endorsed to BAS: Date (Approved/Disapproved) Date endorsed to LHIO: Date released to Hospital:

This pre-authorization is valid for thirty (30) calendar days from date of approval of pre-authorization.