Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

Case No. ________________ **Annex A – PD First**

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, HCI to specify reason/s *and encode*
____

PRE-AUTHORIZATION CHECKLIST
PD First Z Benefits

(Place a ✓ if YES)

QUALIFICATIONS	YES
For pediatric patients, aged 0 to 18 years and 364 days, written informed consent from the parents or guardian is secured.	

Conforme by Patient/Parent/Guardian

____
Printed name and signature

ATTESTED BY ATTENDING NEPHROLOGIST

(Place a ✓ if YES)

QUALIFICATIONS	YES
Diagnosed with end stage renal disease (ESRD) requiring renal replacement therapy, *except for acute kidney injury (e.g. leptospirosis)*	
Has a permanent Tenkchoff peritoneal dialysis catheter properly placed in the abdominal cavity	
Has completed PD initiation in *an accredited health care institution*	
No longer uremic, with stable vital signs	
Patient and/or a caregiver have adequate training to perform PD at home using MANUAL exchanges.	
Absence of any disease of the abdominal wall, such as injury or surgery, burns, hernia, extensive dermatitis involving the abdomen	

QUALIFICATIONS	YES
Absence of any inflammatory bowel diseases (Crohns' disease, ulcerative colitis or diverticulitis)	
Absence of any intra-abdominal tumors or intestinal obstruction	
Absence of active serositis	
Absence of known or suspected allergy to PD solutions	

Certified correct by Attending Nephrologist:

Printed name and signature

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.

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Case No. ________________________

PRE-AUTHORIZATION REQUEST
PD First Z Benefits

DATE OF REQUEST (mm/dd/yy):

This is to request approval for provision of services under the Z benefit package for ______________________________________ in ______________________________________
(NAME OF PATIENT) (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 ____________________

Conforme by Patient/Parent/Guardian:	Certified correct by: (for Service Patients)
(Printed name and signature)	(Printed name and signature) Please tick appropriate box ☐ *Head, Peritoneal Dialysis Unit OR* ☐ Chair, Dept. of Adult Nephrology OR ☐ Chair, Dept. of Pediatric Nephrology OR ☐ Chair, Dept. of Organ Transplantation OR ☐ Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief
Certified correct by:	
(Printed name and signature) Attending Nephrologist	
PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ _ – _	PhilHealth Accreditation No. _ _ _ _ – _ _ _ _ _ _ _ _ – _

(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 *sixty (60)* calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		