Annex A.6: Pre authorization Checklist and Request for Upper Extremities

Revised as of March 2023

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph

Case No. _____

HEALTH *FACILITY (HF)*		
ADDRESS OF *HF*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	SEX ☐ Male ☐ Female
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	***(Answer only if the patient is a dependent; otherwise, write, "same as above")*** 1. Last Name, First Name, Middle Name, Suffix	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

Fulfilled selections criteria ☐ **Yes** If yes, proceed to pre-authorization application
☐ **No** If no, HF to specify reason/s and encode
_____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Upper Extremities

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
SURGICAL URGENCY	☐ Emergency: Date of surgery (mm/dd/yyyy): _____ ☐ Elective

ATTESTED BY ATTENDING PHYSICIAN

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

QUALIFICATIONS	**Yes**
Functional upper extremity prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	
With no more than *two to three (2 to 3)* co-morbid illnesses based on physical status classification based on ASA (low to moderate risk)	

CLINICAL FEATURES	**Yes**
Arm and Forearm: The choice between plating and pinning depends on the fracture location, degree of comminution, displacement and age of the patient. ☐ Humerus fractures (proximal and/or; distal and/or; distal) ☐ Forearm diaphyseal fractures (radius only or; Ulna only or; both radius and ulna) ☐ Wrist (distal radius) ☐ Without malignant/metastatic pathologic fracture;	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. _____ – _____ – _____
	Date signed (mm/dd/yyyy)

Note:
Once approved, the contracted HF 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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PhilHealthOfficial teamphilhealth

PRE-AUTHORIZATION REQUEST
Orthopedic Implants: *Upper Extremities*

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the Z Benefits package for _____ in _____
(NAME OF PATIENT) (NAME OF HF)
under the terms and conditions as agreed for availment of the Z Benefits Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefits package (please tick appropriate box):

☐ Without co-payment
☐ With co-payment, for the purpose of:
_____
_____

Type of implant being applied for:

☐ *Arm and forearm, plating*
☐ *Arm and forearm, pinning*
☐ *Wrist, plating*
☐ *Wrist, pinning*

Conforme by:

(Printed name and signature)
Patient/Parent/Guardian

Certified correct by:

(Printed name and signature)
Attending Orthopedic Surgeon

PhilHealth Accreditation No. | | | | | – | | | | | | | | – | |

Certified correct by:

(Printed name and signature)
Executive Director/Chief of Hospital/
Medical Director/ Medical Center Chief

PhilHealth Accreditation No. | | | | | – | | | | | | | | – | |

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____
_____
(Printed name and signature)
Head or authorized representative, 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 *HF:*			Received by BAS:		
This pre-authorization is valid for sixty (60) calendar days from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HF:		