Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center: (02) 8441-7442 | Trunkline: (02) 8441-7444
www.philhealth.gov.ph

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Case No. _____

Annex "A – TOF"

HEALTH CARE *PROVIDER (HCP)*		
ADDRESS OF *HCP*		
A. PATIENT	1. Last Name, First Name, Middle Name, Suffix	*SEX* ☐ *Male* ☐ *Female*
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER	☐ *Same as patient* *(Answer the following only if the patient is a dependent)* 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, specify reason/s and encode
_____

PRE-AUTHORIZATION CHECKLIST
Tetralogy of Fallot Surgery

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

QUALIFICATIONS	YES
1. Check past history: a. No previous cardiac surgery or intervention such as BTS (Blalock Taussig Shunt) b. No PDA Stenting or c. No residual VSD from previous open heart surgery for total correction	
2. Check physical examination: No hepatomegaly or No edema lower extremities	
3. No congenital chromosomal abnormalities or other congenital defects, except Trisomy 21 (Down's syndrome)	

Place a check mark (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yyyy)
Based on the results of 2D Echocardiogram OR, if applicable, cardiac catheterization OR CT angiogram:[2] a. Confirmed Tetralogy of Fallot OR Confirmed Ventricular Septal Defect and pulmonic stenosis, severe (This is similar to TOF morphology)[3] b. No other associated congenital heart disease (CHD) that includes the following: i. absent pulmonic valve ii. pulmonary valve atresia ii. atrioventricular septal defect (AVSD) c. Confluent and adequate pulmonary artery sizes OR acceptable pulmonary valve annulus d. NO major aorto-pulmonary collateral arteries (MAPCA's)		

[1] Must be done at least within one *fiscal* (1) year from date of *receipt of pre-authorization.*

[2] Attach OFFICIAL 2D ECHO RESULTS in the patient's chart

[3] By morphologic classification of TOF, the components of TOF, which include a VSD with pulmonic stenosis, infundibulovalvar, may be of the same nature as the acyanotic VSD with pulmonic stenosis. The difference lie in the degree of overriding and dilatation of the aorta which is absent in VSD with PS. As such, clinical presentation will be cyanosis in TOF and acyanosis in the pure VSD with PS types. Despite the difference in morphologic components and clinical presentation, the surgical procedure of TOTAL CORRECTION will be the same for both. This includes:

i. VSD Patch Closure
ii. + RVOT repair with or without patch OR
iii. + infundibulectomy of the infundibular muscle

Certified correct by:	Conforme by:
(Printed name and signature) Attending Pediatric Cardiologist	(Printed name and signature) Parent/Guardian
PhilHealth Accreditation No.	

Note:
Once approved, the contracted *HCP* 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
Tetralogy of Fallot Surgery

DATE OF REQUEST (mm/dd/yyyy):

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

_____ in _____
(Patient's *last, first, suffix, middle name*) (Name of *HCP*)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on co-payment and agreed to avail of the benefit package (please tick appropriate box):
☐ *Without co-payment*
☐ *With co-payment, for the purpose of:* _____

Certified correct by:	Certified correct by:
(Printed name and signature) Please tick appropriate box ☐ Chair, Department of Pediatric Cardiology ☐ Chief, Division of Pediatric CV Surgery	(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

(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) _____ *(Printed name and signature)* *Head or authorized BAS representative*		
Received by LHIO/BAS:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to *HCP*:			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 *HCP*:		