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

Case No. ________________

Annex "A2 – VSD"

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
Ventricular Septal Defect (VSD) Closure with Associated Special Clinical Conditions

Place a check mark (✓)

QUALIFICATIONS	YES
Age 1 to 10 years and 364 days	

ATTESTED BY ATTENDING PEDIATRIC CARDIOLOGIST

Place a check mark (✓)

DIAGNOSTICS[1]	YES	DATE DONE (mm/dd/yyyy)
1.Based on 2D Echocardiogram:[2] a. Confirmed ventricular septal defect perimembranous, subaortic, subpulmonic, *or inlet type*		
b. **NO** combined shunts such as atrial septal defect or atrioventricular septal defect; *Aorto-pulmonary window*		
c. **NO** LV Outflow tract obstruction (CHD): such as coarctation of the aorta		
2. Any of the following may be allowed:		
• *Associated patent ductus arteriosus*		
• *Moderate* aortic insufficiency *not warranting replacement*		
• Pulmonary or *Artery Pressure > 2/3 of systemic pressure* with reactive pulmonary bed by *ECHO documented by* cardiac catheterization		
• *Down's Syndrome*		

[1] Must be done at least within six (6) months from date of *receipt of pre-authorization*
[2] Attach OFFICIAL 2D ECHO RESULTS in the patient's chart

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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

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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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

PRE-AUTHORIZATION REQUEST
Ventricular Septal Defect (VSD) Closure with Associated Special Clinical Conditions

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. _ _ _ _ – _ _ _ _ _ _ _ _ – _

(Printed name and signature)
Patient/Parent/Guardian

(For PhilHealth Use Only)

☐ APPROVED

☐ DISAPPROVED (State reason/s) ______________________________

____
(Printed name and signature)
Head or authorized representative, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/BAS:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HCP*:		
This pre-authorization is valid for one hundred eighty (180) calendar days from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s) ______________________________ *(Printed name and signature)* *Head or authorized BAS representative*		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to *HCP*:		

CERTIFIED ISO 9001:2015 COMPANY
PhilHealthofficial teamphilhealth actioncenter@philhealth.gov.ph