Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PHILHEALTH CIRCULAR
No. 2025-0005

TO : **ALL CONTRACTED HEALTH FACILITIES FOR THE Z BENEFITS FOR HEART VALVE REPAIR AND/OR REPLACEMENT FOR VALVULAR HEART DISEASE**

SUBJECT : **Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease**

I. RATIONALE

The Philippines, in particular, has an average of 118,740 cardiac deaths a year. This number increases at least 5% every year, making it the top cause of death for several years[1]. Among these cardiovascular diseases, Valvular Heart Disease (VHD) directly contributes to the annual cardiac deaths. VHD occurs when one or more valves of the heart are not functioning properly which requires valve repair and/or replacement.

As of February 2024, the Philippine Heart Center (PHC) reported that a total of 1,019 patients are enrolled in its valve registry. Analysis of the age and gender distribution among the patients showed a higher frequency of cases in the 41-45 age group, with a nearly equal distribution between males and females, suggesting that VHD impacts a broad demographic spectrum.[2] These findings reflect both the chronic nature of the disease and the cumulative effects of delayed intervention, which often result from barriers to early diagnosis and treatment.

PhilHealth undertook efforts in benefit scoping, evidence generation, and costing model development, as well as conducting costing analyses in collaboration with various relevant stakeholders to develop a benefits package for VHD.

With the enactment of the Republic Act No. 11223, otherwise known as the Universal Health Care Act, PhilHealth is mandated to develop individual health services and benefits that are equitable, affordable and accessible. Improving health insurance coverage for catastrophic diseases can address disparities in healthcare access, particularly among the underprivileged.

---

[1]Posas (2019) National Heart Valve Disease Awareness Transcatheter Aortic Valve Replacement (TAVR) The Revolutionary Catheter Technique for the Heart Valve Disease
[2]Philippine Heart Center (2024)

Thus, the PhilHealth Board of Directors, through Board Resolution No. 2972 s. 2024[3], approved the coverage for heart valve repair/and or replacement for valvular heart disease.

II. OBJECTIVES

This PhilHealth Circular aims to provide coverage for VHD to improve quality of life, enhance patient outcomes, and ensure economic productivity for patients and beneficiaries.

III. SCOPE

This PhilHealth Circular shall apply to all contracted health facilities (HFs) and all others involved in the implementation of the Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease.

IV. DEFINITION OF TERMS

A. Aortic Valve Repair/Replacement – a type of heart valve surgery done to treat a damaged or diseased aortic valve. The aortic valve is one of four valves that control blood flow in the heart. It is between the lower left heart chamber and the body's main artery, called the aorta.

B. Basic or Ward Accommodation – provision of regular meals, bed in shared room, fan ventilation, shared toilet and bath. No other fees or expenses shall be charged to patients admitted in basic accommodation. Special beds, as defined in this PhilHealth Circular shall be treated as basic or ward accommodation under Z Benefits Package.

C. Case-based Provider Payment Mechanism – a provider payment system in which a facility is reimbursed for each discharged patient at a predetermined rate based on the type of case or for groups of cases with similar clinical profiles and resource requirements.

D. Contracted Health Facility – a PhilHealth–accredited health facility that enters into a contract with PhilHealth to provide the provision of essential health services for patients enrolled for the Z Benefits package.

E. Copayment[4] – a predetermined amount agreed upon by the contracted health facility (HF) and PhilHealth that is chargeable to patients to cover the share for amenities, choice of physician, specialist fees for private patients, or any additional or upgraded services during the episode of care before service access to manage moral hazards and adverse incentives. Copayment is an example of an out-of-pocket payment or cost-sharing mechanism intended to share the cost of healthcare between the insured and the insurer.

---

[3]Resolution Approving the Enhancement of the Z Benefits Package for Coronary Artery Bypass Graft (CABG) Surgery, Ventricular Septal Defect (VSD) Tetralogy of Fallot (TOF) and the New Benefits Package for Valve Repair and/or Replacement for Valvular Heart Disease

[4]PC No. 2021-0022. The Guiding Principles of the Z Benefits (Revision 1)

F. **Cost-sharing** – direct payment of a portion of health care costs by the members/dependents when receiving health services. This term generally includes coinsurance, copayment, or similar charges.

G. **Essential Health Services** – a set of identified lists of services that PhilHealth covers for which HFs must provide based on clinical practice guidelines (CPG) and/or expert consensus as approved by the Corporation. These include room and board, drugs and medicines, staff time, laboratory, diagnostic tests, and monitoring procedures, and general supportive care.

H. **Heart Valve Surgery** – a procedure to repair or replace one of the valves covered under this benefits package. These procedures cover mitral valve repair/replacement and aortic valve replacement with or without tricuspid valve annuloplasty.

I. **Lost to Follow-up** – a patient who has not come back as advised for the next consultation or visit, whichever is applicable. In the context of open heart surgeries, this refers to a patient who has not come back as advised for the immediate next cardiac rehabilitation treatment visit or within a month from the scheduled patient visit. As such, visiting the health facility for cardiac rehabilitation services more than a month after the advised scheduled treatment renders the patient lost to follow-up.

J. **Member Empowerment Form (ME Form)** – a document showing that the patient is fully informed of their Z Benefit package, treatment options, treatment schedule and follow-up visits, roles and responsibilities. The ME Form also documents that the contracted health facility provided education, counseling, and other pertinent courses of action. The beneficiary or their guardian or representative and the attending healthcare provider in charge jointly sign the ME Form.

K. **Mitral Valve Repair/Replacement** – types of heart surgery to fix or replace a leaky or narrowed mitral valve. The mitral valve is one of four heart valves that control blood flow in the heart.

L. **Multidisciplinary–Interdisciplinary Team (MDT)**[5] – an approach to patient care involving team members from different professional backgrounds or work disciplines, with each member providing specific services while working collaboratively together to provide the best care to the patient.

M. **Postoperative Complications** – adverse conditions or medical issues that may arise within thirty (30) days after a surgical procedure.

N. **Pre-authorization** – approval process of PhilHealth in which the contracted HF determines whether an individual is qualified to avail of the benefits package based on the minimum selection criteria under the Z Benefits.

[5]Ibid.

O. Special Bed[6] – an accommodation with additional fixtures and amenities that are essential to the provision of specialty care of patients, which includes, but are not limited to, critical care units, intensive care units, and isolation rooms.

P. Valvular Heart Disease (VHD) – a structural or functional abnormality of cardiac valves: the aortic, mitral, tricuspid, and pulmonary valves, leading to disrupted blood flow.

V. POLICY STATEMENTS

A. Benefits Availment

1. All Filipinos are automatically entitled to avail of this benefits package. PhilHealth beneficiaries shall comply with the existing membership eligibility guidelines.

2. All patients who meet the clinical criteria shall be eligible to avail of the Z benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease. The patient selection criteria are detailed in the Pre-authorization Checklist and Request Forms (Annex A.1. and A.2.), which shall serve as the basis for PhilHealth's approval. The approved pre-authorization shall be valid for one hundred eighty (180) calendar days from the approval date.

3. PhilHealth shall contract capable accredited health facilities (Annex B: Supplementary Rules in Accrediting and Contracting Health Facilities) to provide the essential health services (Annex C: List of Essential Health Services for Heart Valve Repair and/or Replacement for Valvular Heart Disease) for the Z Benefits package for Heart Valve Repair and/or Replacement for Valvular Heart Disease.

4. The designated liaison of the contracted HF shall submit the properly accomplished original copy of the Pre-authorization Checklist and Request Form and Annex D: Member Empowerment Form (ME Form) to the Local Health Insurance Office (LHIO) or the office of the Head of the PhilHealth Benefits Administration Section (BAS) who has jurisdiction over the contracted HFs. These documents may also be scanned and emailed to the respective PROs for approval.

5. This benefits package covers the essential health services for surgical procedures and cardiac rehabilitation services involving heart valve repair and/or replacement for valvular heart disease.

6. The forty-five (45) day annual benefit limit shall not apply when a patient avails of this benefits package.

7. Patients with rheumatic fever/rheumatic heart disease who have undergone heart valve replacement/repair and have availed of this benefits package

[6]DOH AO No. 2021-0015: Standards on Basic and Non-Basic Accommodation in All Hospitals

may be enrolled in the outpatient benefit package for the secondary prevention of rheumatic fever/rheumatic heart disease[7] provided that, they are eligible based on the set clinical criteria of the said benefits package.

8. The contracted HF shall discuss the ME Form with the patient, including an explanation of the cost-sharing aspect of the benefits package. Its primary purpose is to empower patients to actively participate in healthcare decision-making by providing them with essential information and education regarding their health condition and available treatment options.

9. The contracted HFs shall not charge copayment for essential health services and post-operative complications for patients admitted in basic or ward accommodation or if admitted in special beds.

10. The contracted HF may charge copayments or out-of-pocket (OOP) payments for services not included in the list of essential health services, choice of physicians, specialist fees for private patients, and amenities provided to the patient but not covered by the Z Benefits package. These copayments are mutually agreed upon by the patient and the contracted HF during the discussion of the ME Form for services beyond the scope of essential health services.

11. PhilHealth shall reimburse drugs listed in the latest edition of the Philippine National Formulary (PNF). PhilHealth reiterates the mandate of the Health Technology Assessment, which provides positive recommendations for any proposal to cover drugs, medicines, or biologicals not listed in the latest PNF, new health technologies, surgical procedures, and other treatment interventions.

B. Responsibilities of Contracted Health Facilities

1. The contracted HFs shall adhere to the selection criteria outlined in the pre-authorization checklist and request form when determining patients' eligibility to avail of this benefits package.

2. The contracted HFs shall inform all patients requiring heart valve repair and/or replacement for valvular heart disease about the Z Benefits package. If patients are qualified, they shall be enrolled based on set rules specified in this policy.

3. The Multidisciplinary-interdisciplinary team (MDT) shall evaluate patients with valvular heart disease qualified for valve intervention under the Z Benefits. The MDT shall be composed of the following:

   a. For Adult Patients
      a.1. Thoracic and Cardiovascular Surgeon (TCVS)
      a.2. Attending Cardiologist
      a.3. Cardiac Anesthesiologist

[7]PhilHealth Circular No. 2019-0005: Outpatient Benefit Package for the Secondary Prevention of Rheumatic Fever/Rheumatic Heart Disease

a.4. Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
a.5. Intensivist

b. For Pediatric Patients
b1. TCVS
b2. Attending Pediatric Cardiologist
b3. Pediatric Cardiac Anesthesiologist
b4. Cardiac Rehabilitation Specialist or Physical Medicine and Rehabilitation Specialist
b5. Pediatric Intensivist

4. The contracted HF shall manage any postoperative complications of VHD such as infections, bleeding, blood clots, or side effects from medications.

5. The contracted HFs shall not balance bill any patient beyond the amount prescribed in the benefits package for covered services. In cases of copayment, the contracted HF shall not charge the patient more than the agreed copayment at the point of service.

6. The contracted HFs shall appoint at least one (1) Z Benefits Coordinator, whose responsibilities are outlined in PhilHealth Circular (PC) No. 2021-0022 "The Guiding Principles of the Z Benefits (Revision 1)," provided that, each Z Benefits Coordinator shall be permitted to manage a maximum of three (3) Z Benefits packages.

7. The contracted HFs shall maintain either digital or physical copies of all medical records for monitoring and post-audit purposes by PhilHealth.

8. As stipulated in the RA No. 11223 (Universal Health Care Act), Chapter IV, Sec. 18 (b), there shall be no differentiation between facility and professional fees (PF). PhilHealth shall credit all payments to the accounts of contracted private and government HFs.

C. Lost to Follow-up

1. The contracted HFs shall exhaust all efforts to contact, navigate, or obtain information about the whereabouts or situation of their patients within thirty (30) days after the scheduled cardiac rehabilitation treatment visit.

2. Patients who have not been declared lost to follow-up and return within thirty (30) days after their advised next cardiac rehabilitation session may continue the remaining rehabilitation sessions upon reassessment and referral by the attending cardiologist. The cardiac rehabilitation services shall be covered under this policy.

   Patients declared lost to follow-up are no longer eligible to continue availing of the said Z Benefits for the particular episode of care.

3. In case of patients who are declared lost to follow-up or when the patient expires, the contracted HFs shall file claims based on the applicable scenarios:

   a. The contracted HF shall submit to PhilHealth an original copy notarized sworn declaration that the patient is declared lost to follow-up. Claims submission of patients declared lost to follow-up shall be submitted within sixty (60) days from such declaration.

   b. If the patient expires during treatment, the contracted HF shall submit a photocopy of the death certificate or an original copy notarized sworn declaration issued by the authorized government agencies as an attachment to the claims. The contracted HF shall submit their claims within sixty (60) days from the receipt of the death certificate or notarized sworn declaration[8] issued by authorized government agencies.

4. The claims for cardiac rehabilitation services of patients who expired or declared lost to follow-up shall be paid on a prorated basis.

D. Package Code and Description Rate

The package code of Z Benefits Package for heart valve repair and/or replacement for valvular heart disease are as follows:

Package Code	Description	Package Rate (PHP)	Filing Period
Z034A1	Mitral Valve Replacement with Tricuspid Valve Annuloplasty (Adult or Pediatric)	810,000	Within 60 days after discharge from the surgery
Z034A2	Aortic Valve Replacement with Tricuspid Valve Annuloplasty (Pediatric)		
Z034B1	Mitral Valve Replacement (Adult or Pediatric)	762,000	
Z034B2	Aortic Valve Replacement (Adult or Pediatric)		
Z034C	Mitral and Tricuspid Valve Repair (Pediatric)	690,000	
Z034D	Mitral Valve Repair (Pediatric)	642,000	

[8]PhilHealth Circular No. 2021-0022: The Guiding Principles of the Z Benefits (Revision 1)

Package Code	Description	Package Rate (PHP)	Filing Period
Z034E1	Cardiac Rehabilitation (Maximum of 4 sessions) (Adult)	15,000	Within 60 days after the 4th rehabilitation session
Z034E2	Cardiac Rehabilitation (Maximum of 4 sessions) (Pediatric)	6,500	

Table 1: Package Code, Description, Rate, and Filing Schedule of Z Benefits for Heart Valve Repair and/or Replacement and Cardiac Rehabilitation Services for Valvular Heart Disease

E. Claims Filing and Reimbursement

1. The contracted HF shall provide the prescribed essential health services to patients covered by this benefits package.

2. There shall be no direct filing of claims by members or beneficiaries. All claims shall be filed by contracted health facilities.

3. The contracted HF shall be responsible for the accuracy, adherence to guidelines, and efficient handling of all claims filed on behalf of patients. All required documents, forms, and attachments should be properly filled out before claims filing. The contracted HFs shall submit the complete requirements for claims submission, including supporting documents.

4. The contracted HFs shall indicate the corresponding Z benefits package code of the treatment provided to the patient in the Claim Form (CF) 2. In case of deviation from the approved pre-authorization, the contracted HFs shall attach a justification letter signed by the attending physician and indicate the Z benefits package code of the actual surgery performed on the patient in the CF2.

5. The Z Satisfaction Questionnaire (Annex E) shall be accomplished by all patients enrolled in Z Benefits prior to final discharge disposition from the contracted HF. These are validated during field monitoring by PhilHealth and shall be used as the basis of the Corporation for benefits enhancement, policy research, and quality improvement purposes.

6. The contracted HFs shall follow the documentary requirements for filing claims, as prescribed in the Checklist of Requirements for Reimbursement (Annex F), including the Transmittal Form (Annex G), which shall be attached per claim or batch of claims.

7. The required signatories shall affix their signatures to attest that the services were provided to patients.

8. If the patient expires, the contracted HF may file their claim for reimbursement based on the number of sessions on a prorated basis.

9. For patients who are declared lost to follow-up, the contracted HF must have rendered at least three (3) cardiac rehabilitation sessions (Adult or Pediatric) to be eligible to file a claim on a prorated basis.

10. The contracted HFs shall properly indicate the OOP and/or copayment of the member/patient and other funding sources in PhilHealth CF2 Part III, "Consumption Benefits," and in the Statement of Account (SOA).

11. The contracted HFs shall follow existing guidelines of the SOA[9] requirement for claims submission under the Z Benefits.

12. Contracted HFs shall follow all relevant laws, such as RA No. 9994 or the "Expanded Senior Citizens Act of 2010" and RA No. 10754 or the "Act Expanding the Benefits and Privileges of Persons with Disability (PWD)," including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on DOH-DSWD-PCSO-PHIC Joint Administrative Order No. 2020-0001 [Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019"].

    With this, PhilHealth benefits and all mandatory discounts provided by law, such as senior citizen and PWD discounts, shall be deducted first from the patient's total hospital bill. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall be applied after PhilHealth deductions and complement the PhilHealth benefits packages.

13. Contracted HFs may file a motion for reconsideration (MR) or appeal any claims denied by PhilHealth in accordance with existing policies.

14. Existing rules on late filing shall apply. If the delay in claims filing is caused by natural calamities or other fortuitous events, the Corporation's policy on granting special privileges to those affected by such events shall be applicable.

F. Claims Payment and Evaluation

1. PhilHealth shall reimburse contracted HFs that render the essential health services prescribed to patients under this benefit package. Services provided shall be properly documented in the Checklist of Essential Health Services (Annex H).

[9] PhilHealth Circular No. 2022-0024: Statement Of Account (SOA) Requirement For Z Benefit Claims Submission

2. PhilHealth shall pay the contracted HFs based on the predetermined package rates using a case-based payment. For incomplete cardiac rehabilitation services, payment shall be made on a prorated basis as stated in Section V.E.8 and 9 of this policy.

3. PhilHealth shall review the completeness of all forms submitted by the contracted HFs. The PROs and LHIOs shall have the prerogative not to accept incomplete documents. However, they should directly coordinate with the contracted HFs regarding the deficiencies in the documents submitted. Once the documents are complete, the contracted HF shall submit these to PhilHealth for payment of claims within the required filing schedule.

4. PhilHealth shall apply the "return to sender (RTS)" policy only for claims filed with incomplete data or documentary requirements. However, inconsistencies in data or information contained in the documents or non-provision of essential health services are grounds for automatic denial of the claim.

   Upon receipt of the notice of RTS, the contracted HFs shall comply with the deficiencies within the prescribed period based on the existing rules and regulations set by PhilHealth.

5. PhilHealth shall have the right to subject any or all claims to medical review before and/or after payment or reimbursement of the contracted HFs, following the existing guidelines.

6. Any change of member/patient category after approval of the pre-authorization shall not affect the claims filed by the contracted HF.

7. Any amount declared in the SOA that is below or above the package rates shall not be interpreted as over or underpayment. PhilHealth can adjust payment rates in consideration of updates in standards of care and cost of standard health services validated with content experts.

8. PhilHealth shall process all claims submitted by the contracted HFs within thirty (30) working days upon receipt of claims applications, provided that the required documents and attachments are complied with.

9. Claims filed by the contracted HF shall be denied based on the following instances:

   a. If a required essential health service was not provided by the contracted HF;
   b. Late filing;
   c. Inconsistency of data and information contained in the claims application.

G. Monitoring

1. PhilHealth shall enforce current policies and guidelines on monitoring the performance of contracted HFs in implementing the Z Benefits Package for Heart Disease Repair and/or Replacement for Valvular Heart Disease and establish strict control mechanisms to ensure quality healthcare delivery and prevent adverse provider behaviors and non-compliance with existing rules.

2. PhilHealth also encourages content experts to review and conduct appropriate studies on healthcare providers' actual practices during the implementation of the Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease, especially documenting adverse provider behaviors resulting in cost-push inflation, such as unwarranted increases in hospital charges.

3. PhilHealth beneficiaries are strongly encouraged to provide feedback or report any concerns about the implementation of the Z Benefits policy or their benefit availment experience by contacting the Corporate Action Center (CAC) through the hotline at (02) 8862-2588 or via email at actioncenter@philhealth.gov.ph.

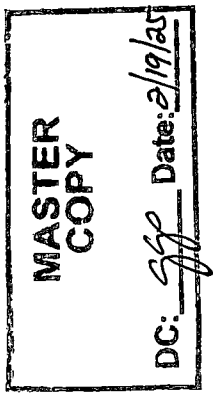
4. Field monitoring activities shall be conducted for the service provision by contracted HFs. It shall follow the guidance, tools, and consent forms provided in PC No. 2021-0022.

5. The Corporation shall establish the performance indicators and outcome measures to monitor compliance with the policies of this Circular and the general treatment algorithm in collaboration with relevant stakeholders and experts and incorporate the indicators into the relevant monitoring policies.

H. Marketing and Promotion

PhilHealth shall conduct communication and social marketing activities to educate the general public and increase their awareness of the benefits package and to promote informed decision-making and participation among patients, healthcare professionals, healthcare providers, and other stakeholders, including marketing and promotional activities shall be undertaken following the Integrated Marketing and Communication Plan of PhilHealth.

To further widen the reach to the general public, most especially to beneficiaries, PhilHealth likewise encourages contracted healthcare facilities to advertise the Z Benefits packages through different communication channels, including but not limited to respective remote or online platforms, provided that these are in accordance with the policies of each benefits package and the social marketing and communication plan of PhilHealth.



I. Policy Review

PhilHealth shall conduct regular policy reviews of the benefits package in consultation and collaboration with relevant stakeholders, experts, and technical staff representatives from the Corporation. This PhilHealth Circular shall be enhanced as necessary based on the results of the policy review.

J. Annexes

Annex A: Pre-authorization Checklist and Request Form

Annex A.1. : Pre-authorization Checklist and Request Form for Heart Valve Replacement for Valvular Heart Disease (Adult)

Annex A.2. : Pre-authorization Checklist and Request Form for Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pediatric)

Annex B: Supplementary Rules in Accrediting and Contracting Health Facilities

Annex C: List of Essential Health Services for Heart Valve Repair and/or Replacement for Valvular Heart Disease

Annex D: Member Empowerment Form

Annex E: Z Satisfaction Questionnaire

Annex F: Checklist of Requirements for Reimbursement

Annex G: Transmittal Form

Annex H: Checklist of Essential Health Services

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of RA No. 7875, as amended by RA Nos. 9241 and 10606 (National Health Insurance Act of 2013), RA No. 11223 (Universal Health Care Act), and their respective Implementing Rules and Regulations, including the PhilHealth Rules on Administrative Cases (PROAC).

VII. TRANSITORY CLAUSE

A. Upon publication of this PhilHealth Circular, PhilHealth shall disseminate information to contracted health facilities and ensure the availability of forms specified in this policy on the PhilHealth website and the deployment of necessary enhancements in the claims system.

B. While the necessary system is being developed, the contracted HFs shall submit the claims manually. PhilHealth shall issue a corresponding advisory to inform the health facilities once the benefits package is fully integrated into the system.

C. PhilHealth shall contract capable health facilities to provide the essential health services and process pre-authorization requests from contracted HFs upon effectivity of this PhilHealth Circular.

VIII. SEPARABILITY CLAUSE

In the event that any part or provision of this PhilHealth Circular is declared unauthorized or invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect on March 1, 2025, after its publication in the Official Gazette or in a newspaper of general circulation. Three (3) certified copies shall be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

EDWIN M. MERCADO, MD, MHA, MMSc
Acting President and CEO

Date signed: 2/18/2025

MASTER COPY
DC: Date: 2/19/25

Annex A.1: Pre-authorization Checklist and Request Form for Heart Valve Replacement for Valvular Heart Disease (Adult)

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER □ Same as above *(Answer only if the patient is a dependent)	Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐☐☐ - ☐	

MASTER COPY Date: 2/19/25

Pre-authorization Checklist and Request Form
Heart Valve Replacement for Valvular Heart Disease (Adult)

Place a (✔) or appropriate remarks

TYPE OF PROCEDURE*	Remarks
Mitral valve replacement with tricuspid valve annuloplasty	
Mitral valve replacement	
Aortic valve replacement	

*The contracted HF shall select one surgical procedure to be performed on the patient

Place a (✔) or appropriate remarks

General Criteria	Remarks
At least 19 years old	
EUROscore II and STS score <5% mortality	
Life expectancy of more than 5 years	
For patients aged 45 years old and above, no evidence of coronary artery disease based on coronary angiogram (Coronary angiogram should be within 1 year of procedure)	
No previous history of Valvular Surgery	
Not in decompensated heart failure New York Heart Association (NYHA) Classification IV	
No other concomitant surgeries (CABG, Permanent Pacemaker Insertion (PPI), aortic root repair) planned with valve surgery	
No active malignancies	
No liver cirrhosis	
No previous cardiac or thoracic surgery	

Place a (✔) on the appropriate procedure to be performed and remarks

☐ **Mitral Valve Replacement**	**Remarks**
Severe Mitral Stenosis a. Symptomatic NYHA II b. MVA <1.5 with Wilkins valve score of 9 or more)	
Severe Primary or Rheumatic Mitral Regurgitation a. Symptomatic NYHA II b. Left Ventricular End-Systolic Diameter (LVESD) >/=4cm c. Left ventricular ejection fraction (LVEF) >45%	

☐ **Mitral Valve Replacement with Tricuspid valve annuloplasty**	**Remarks**
Severe Mitral Stenosis with Tricuspid Regurgitation a. Symptomatic NYHA II b. MVA <1.5 with Wilkins valve score of 9 or more) c. With moderate to severe tricuspid regurgitation d. Dilated tricuspid valve (TV) annulus >/=4cm or index TV annulus >/=2.1	
Severe Primary or Rheumatic Mitral Regurgitation with Tricuspid Regurgitation a. Symptomatic NYHA II b. Left Ventricular End-Systolic Diameter (LVESD) >/=4cm c. Left ventricular ejection fraction (LVEF) >45% d. Moderate to severe tricuspid regurgitation e. Dilated tricuspid valve (TV) annulus >/=4cm or index TV annulus >/=2.1	

☐ **Aortic Valve Replacement**	**Remarks**
Severe Aortic Stenosis a. Any aortic stenosis presenting with symptoms of chest pain, syncope and shortness of breath, hypotension on stress testing, b. Asymptomatic with Aortic valve area of < 1.0 cm2 and gradient of >/= 40 mmHg	
Severe Aortic Regurgitation a. Symptomatic NYHA II with LVEF >55% b. Symptomatic NYHA II-III with LVEF of less than 55% but more than 25% c. Left ventricular end-systolic dimension of more than 5.0 cm with a stroke volume of more than 25mm/m2	

*The contracted HF shall select one surgical procedure to be performed on the patient

Certified correct by:	Conforme by:
(Printed name and signature) Attending Cardiologist or Cardiovascular Surgeon	(Printed name and signature) ☐ Patient ☐ Parent ☐ Guardian
PhilHealth Accreditation No. ☐☐☐☐.☐☐☐☐☐☐☐.☐ Date signed (mm/dd/yyyy)	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 Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease.** Please do not leave any item blank.

MASTER COPY
DC: Date: 2/19/25

PRE-AUTHORIZATION REQUEST

Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease (Adult)

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the **Z Benefits Package for Valvular Heart Disease Repair and/or Replacement**

_____ in _____

(Patient's last, first, suffix, middle name) (Name of HF)

under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient is aware of the PhilHealth policy on copayment and agreed to avail of the benefit package (please tick appropriate box):

□ Without copayment

□ With copayment, for the purpose of:

_____

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) □ Patient □ Parent □ Guardian	(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):			(Printed name and signature) Head or authorized BAS representative		
□ Approved □ Disapproved			**Activity**	**Initial**	**Date**
Released to HF:			Received by BAS:		
This pre-authorization is valid for one hundred eighty (180) calendar days from the date of approval of request.			□ Approved □ Disapproved		
			Released to HF:		

MASTER COPY Date: 3/19/25 DC:

Annex A.2: Pre-authorization Checklist and Request Form for Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pediatric)

PhilHealth
Your Partner in Health

BAGONG PILIPINAS

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No._____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	
B. MEMBER □ Same as above (Answer only if the patient is a dependent)	Last Name, First Name, Middle Name, Suffix	SEX □ Male □ Female
	PhilHealth ID Number: ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

MASTER COPY Date: 2/19/25 DC:

Pre-authorization Checklist and Request Form

Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pediatric)

Place a (✔) or appropriate remarks

TYPE OF PROCEDURE*	Remarks
Mitral valve replacement with tricuspid valve annuloplasty	
Aortic valve replacement with tricuspid valve annuloplasty	
Mitral valve replacement	
Aortic valve replacement	
Mitral valve repair with Tricuspid valve repair	
Mitral valve repair	

*The contracted HF shall select one surgical procedure to be performed on the patient

Place a (✔) or appropriate remarks

General Criteria	Remarks
EUROscore II and STS score <5% mortality	
Life expectancy of more than five (5) years	
No previous history of Valvular Surgery	
Not in decompensated heart failure New York Heart Association (NYHA) Classification IV	
No other concomitant surgeries (CABG, Permanent Pacemaker Insertion [PPI], aortic root repair) planned with valve surgery	

General Criteria	Remarks
No active malignancies	
No liver cirrhosis	
No previous cardiac or thoracic surgery	
2D echo done within six (6) months	

Place a (✔) on the appropriate procedure to be performed and remarks

☐ **Mitral valve replacement**	**Remarks**
1. Age at least 15 years old but not more than 18 years and 364 days	
2. Etiology: a. If rheumatic etiology-controlled activity with at least two (2) weeks anti-inflammatory Check inflammatory markers b. If with infective endocarditis and/or vegetation with negative blood CS completed at least 2 weeks antibiotic	
3. Check any one of the following: a. SEVERE MITRAL STENOSIS MVA-<1.5 with Wilkins valve score 9 or more) or combined with Mitral regurgitation, mild to moderate b. SEVERE MITRAL REGURGITATION i. Symptomatic with NYHA II ii. Vena contracta >0.7 cm, RF ≥50% iii. Left Ventricular end systolic diameter >/= 4; Or LVESD enlarged by z score; OR LV end diastolic diameter >/= 5.5 cm; iv. Preserved LV function ≥55%	
4. Institution Valve team Approval for the following: a. Symptomatic NYHA III-IV b. With depressed LV function < 45 % c. Age 10-15 years old	
5. Intraoperative TEE finding of Mitral regurgitation RF > 50% after MV repair	

☐ **Mitral valve replacement with tricuspid valve annuloplasty**	**Remarks**
1. Age up to 18 years and 364 days old	
2. With concomitant moderate to severe tricuspid regurgitation	
3. Dilated TV annulus >/=4cm or index TV annulus >/=2.1	
4. Intraoperative TEE finding of TR moderate to severe with dilated TV annulus	

MASTER COPY Date: 2/19/25

☐ **Mitral valve repair**	**Remarks**
1. Age less than 15 years old	
2. Check etiology a. If rheumatic etiology-controlled activity with at least 2 weeks anti-inflammatory (Check inflammatory markers) b. If with infective endocarditis and/or vegetation with negative blood CS completed at least 2 weeks antibiotic	
3. SEVERE MITRAL REGURGITATION a. Symptomatic with NYHA II -III; b. Vena contracta >0.7 cm, RF >50%; c. Left Ventricular end systolic diameter >/= 4; Or LVESD enlarged by z score; OR LV end diastolic diameter >/= 5.5 cm; d. Preserved LV function ≥55%	

☐ **Mitral valve repair with Tricuspid valve repair**	**Remarks**
1. Age up to 18 years and 364 days old	
2. Mitral valve regurgitation criteria fulfilled as above a. Symptomatic with NYHA II -III; b. Vena contracta >0.7 cm, RF >50%; c. Left Ventricular end systolic diameter >/= 4; Or LVESD enlarged by z score; OR LV end diastolic diameter >/= 5.5 cm; d. Preserved LV function ≥55%;	
3. Check concomitant Tricuspid Valve (if applicable) (Before or after repair on intraoperative echocardiogram) a. Moderate or Severe Tricuspid Valve Regurgitation b. Dilated Tricuspid valve annulus > 4.0 mm c. With or without RV dilatation	

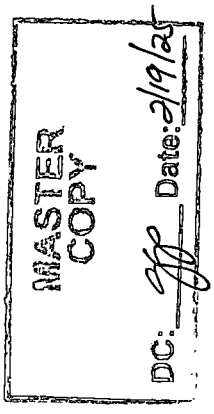
☐ **Aortic valve replacement**	**Remarks**
1. Age at least 15 years old	
2. Check etiology: a. If rheumatic Controlled RF activity or at least 2 weeks anti inflammatory b. If with infective endocarditis with negative blood Culture or antibiotic for at least 2 weeks c. If with vegetation – require Infectious service clearance after antibiotic load	
3.a. SEVERE AORTIC STENOSIS (AS) Stage C1 1. Asymptomatic 2. Aortic valve annulus < 1.0cm2 and 3. AV mean gradient >/=40mmHG 4. Left ventricular ejection fraction (LVEF)>50% 3.b. SEVERE AORTIC STENOSIS WITH REDUCED EJECTION FRACTION or Stage C2 1. Asymptomatic or at least NYHA Class II 2. Aortic valve area <1.0mm2 gradient >/= 40mmhg 3. Left ventricular ejection fraction (LVEF) < 50% classical low flow low gradient AS 3.c. SEVERE RHEUMATIC AORTIC REGURGITATION 1. Symptomatic with at least NYHA II LVEF>55% 2. Left Ventricular end systolic diameter >5.5 or LV end diastolic diameter > 7.0; OR enlarged LVESD or LVEDD by z score	
4. With Approval of Valve team for a. Age <15 years old b. Vegetation with risk for embolization as above as urgent c. Symptomatic with NYHA III-IV d. With depressed LV function <55% but> 25%	

☐ **Aortic valve replacement with Tricuspid valve annuloplasty**	**Remarks**
1. Aortic valve replacement criteria fulfilled as indicated above	
2. If rheumatic etiology, check concomitant Tricuspid Valve Regurgitation (if applicable) a. Moderate or Severe Tricuspid Valve Regurgitation b. Dilated Tricuspid valve annulus > 4.0 mm c. With or without Right Ventricular (RV) dilatation	

Certified correct by:	Conforme by:
(Printed name and signature) Attending Pediatric Cardiologist or Cardiovascular Surgeon	(Printed name and signature) ☐ Patient ☐ Parent ☐ Guardian
PhilHealth Accreditation No.	Date signed (mm/dd/yyyy)
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 Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease.** Please do not leave any item blank.



PRE-AUTHORIZATION REQUEST

Z Benefits Package for Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pediatric)

DATE OF REQUEST (mm/dd/yyyy):

This is to request approval for provision of services under the **Z Benefits Package for Valvular Heart Disease Repair and/or Replacement** for

_____ in _____

(Patient's last, first, suffix, middle name) (Name of HF)

under the terms and conditions as agreed for availment of the 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) Attending Cardiologist	(Printed name and signature) Attending Cardiovascular Surgeon
PhilHealth Accreditation No.	PhilHealth Accreditation No.

Conforme by:	Certified correct by:
(Printed name and signature) ☐ Patient ☐ Parent ☐ Guardian	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
	PhilHealth Accreditation No.

MASTER COPY Date: 2/19/25

(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 HF:			Received by BAS:		
The pre-authorization shall be valid for one hundred eighty (180) calendar days from the date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HF:		

PhilHealth
Your Partner in Health
BAGONG PILIPINAS
Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Supplementary Rules in Accrediting and Contracting Health Facilities

1. PhilHealth shall contract qualified accredited HFs to offer the services under the Z Benefits Package for Open Heart Surgeries. These contracted HFs are required to provide the offered services of the benefits package to qualified patients.

2. The contract shall contain the terms and conditions agreed upon by PhilHealth and the accredited HFs. Co-payment, if applicable, shall not exceed the corresponding package rate.

3. The accredited HFs shall submit co-payment proposals to PhilHealth. They shall identify the amenities, specialist fees for private patients, or any additional or upgrade of services beyond the coverage of the benefits package including specialist fees, if applicable. In cases of cost variance, the contracted HFs shall provide the necessary information to support the co-payment proposal or adjustment to the existing rates.

4. PhilHealth shall negotiate the proposed rates of the health services considered for inclusion in the co-payment arrangement submitted by the accredited HFs.

5. PhilHealth shall examine the co-payment proposal of the accredited HFs if these services are necessary for the patient's care but are not included in the identified essential health services.

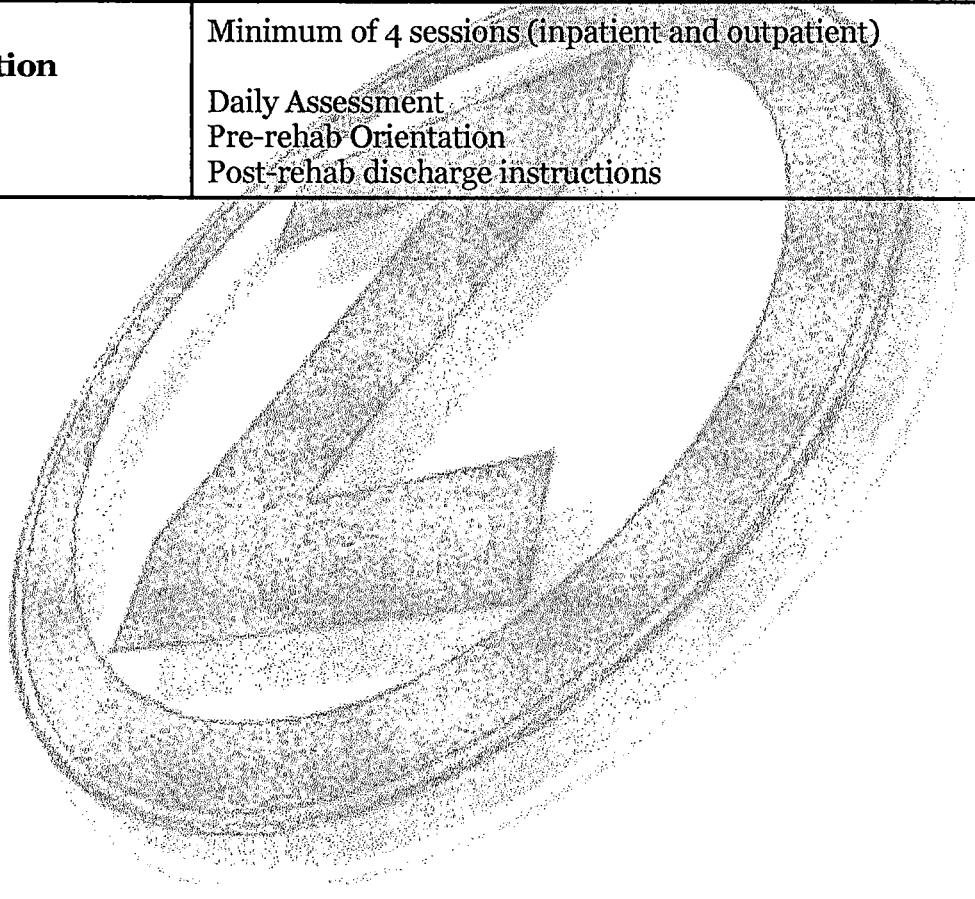
6. For further guidance, please refer to PhilHealth Circular No. 2022-0012 "Contracting of a Health Facility as a Z Benefits Provider (Revision 1)" or its subsequent amendments.

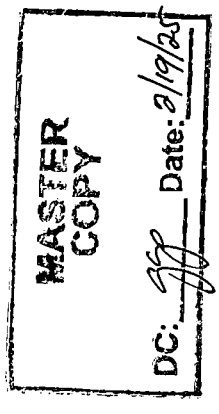
Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

List of Essential Health Services for Heart Valve Repair and/or Replacement for Valvular Heart Disease

Package Inclusions	Covered Services
Laboratory Tests and Diagnostics	CBC with platelet Blood typing Prothrombin time Activated partial thromboplastin time Electrolytes (Na, K, iCa, Cl, Mg) Creatinine Albumin BUN SGPT (as indicated) SGOT (as indicated) Urinalysis Chest X-ray (PA lateral) 12 lead ECG Arterial blood gas (ABG) CBG monitoring 2DEcho with Doppler (transthoracic, or transesophageal, or intra-op transesophageal echo)
Treatment	Incentive spirometry Blood products screening Nebulization Mechanical ventilator use
Medications	Beta blockers (Ex. metoprolol) Anticoagulant (Warfarin) As indicated/needed: Antiplatelet (ex. aspirin) Phenoxymethylpenicillin ACE inhibitors, ARB (Ex. captopril, enalapril) Statin (Ex. rosuvastatin) Sedation/pain (Ex. paracetamol IV, oral, diazepam, tramadol) Antibiotics (Ex. amikacin) GI medicine (Ex. omeprazole IV, oral) Pulmonary medicine (Ex. salbutamol, budesonide neb, salbutamol/ipratropium, acetylcysteine) Hemodynamic support (Ex. nitroglycerin amp,

Package Inclusions	Covered Services
	dobutamine) Electrolytes (Ex. KCl, Mg_2SO_4, Ca gluconate) Calcium channel blockers (Ex. diltiazem) Digoxin
Procedure	Heart Valve Surgery (Replacement or Repair) Inclusive of perfusion and anaesthesia
	Immediate Postoperative Care at Surgical ICU (SICU)
Mechanical Devices (For heart valve replacement surgery)	Prosthetic mitral or aortic valve (mechanical valve)
	Prosthetic mitral or aortic valve (mechanical valve) including tricuspid annuloplasty ring
Cardiac rehabilitation	Minimum of 4 sessions (inpatient and outpatient) Daily Assessment Pre-rehab Orientation Post-rehab discharge instructions





Annex D: Member Empowerment Form (ME Form)

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Numero ng kaso: _____
Case No.

MEMBER EMPOWERMENT FORM

Magpaalám, tumulong, at magbigay kapangyarihan
Inform, Support & Empower

Mga Panuto:
Instructions:

Ipaliliwanag at tutulungan ng kinatawan ng ospital ang pasyente sa pagsasagot ng ME form.
The health care provider shall explain and assist the patient in filling-up the ME form.
Isulat nang maayos at malinaw ang mga impormasyon na kinakailangan.
Legibly print all information provided.
Para sa mga katanungang nangangailangan ng sagot na "oo" o "hindi", lagyan ng marka () ang angkop na kahon.
For items requiring a "yes" or "no" response, tick appropriately with a check mark ().
Gumamit ng karagdagang papel kung kinakailangan. Lagyan ito ng kaukulang marka at ilakip ito sa ME form.
Use additional blank sheets if necessary, label properly and attach securely to this ME form.
Ang kinontratang ospital na magkakaloob ng dalubhasang pangangalaga sa pagpaparami ng kopya ng ME Form.
The ME form shall be reproduced by the contracted health facility (HF) providing specialized care.
Dalawang kopya ng ME form ang kailangang ibigay ng kinontratang ospital. Ang mga kopyang nabanggit ay ilalaan para sa pasyente at sa ospital.
Duplicate copies of the ME form shall be made available by the contracted HF—one for the patient and one as file copy of the contracted HF providing the specialized care.
Para sa mga pasyenteng gagamit ng Z Benefit for Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH), ukol sa pagpapalit ng artipisyal na ibabang bahagi ng hita at binti, o Z Benefits para sa mga batang may kapansanan, isulat ang N/A sa tala B2, B3 at D6. Para naman sa Peritoneal Dialysis (PD) First Z Benefits, isulat ang N/A para sa tala B2 at B3.
For patients availing of the Z Mobility Orthoses Rehabilitation Prosthesis Help (ZMORPH) for fitting of the external lower limb prosthesis, or Z Benefits for children with disabilities, write N/A for items B2, B3 and D6 and for PD First Z Benefits, write N/A for items B2 and B3.

MASTER COPY
DC: ___ Date: 2/1/25

PANGALAN NG OSPITAL *HEALTH FACILITY (HF)*
ADRES NG OSPITAL *ADDRESS OF HF*

A. Impormasyon ng Miyembro/ Pasyente
A. Member/Patient Information

PASYENTE (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
PATIENT (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG PASYENTE ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF PATIENT

MIYEMBRO (kung ang pasyente ay kalipikadong makikinabang) (Apelyido, Pangalan, Panggitnang Apelyido, Karagdagan sa Pangalan)
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)

NUMERO NG PHILHEALTH ID NG MIYEMBRO ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐☐
PHILHEALTH ID NUMBER OF MEMBER

PERMANENTENG TIRAHAN
PERMANENT ADDRESS

Petsa ng Kapanganakan (Buwan/Araw/Taon) *Birthday (mm/dd/yyyy)*	Edad *Age*	Kasarian *Sex*
Numero ng Telepono *Telephone Number*	Numero ng Cellphone *Mobile Number*	Email Address *Email Address*

Kategorya bilang Miyembro:
Membership Category:

Direct contributor
Direct contributor

- ☐ Empleado ng pribadong sector
  Employed private
- ☐ Empleado ng gobyerno
  Employed government
- ☐ May sariling pinagkakakitaan
  Self-earning
  - ☐ Indibidwal
    Individual
  - ☐ Sole proprietor
    Sole proprietor
  - ☐ Group enrollment scheme
    Group enrollment scheme
- ☐ Kasambahay / *Household Help*
- ☐ Tagamaneho ng Pamilya/ *Family driver*
- ☐ Filipinong Manggagawa sa ibang bansa
  Migrant Worker/OFW
  - ☐ Land-based *Land-based*
  - ☐ Sea-based *Sea-based*
- ☐ Habambuhay na kaanib/ *Lifetime Member*
- ☐ Filipino na may dalawang pagkamamamayan/Nakatira sa ibang bansa
  Filipino with Dual Citizenship/Living abroad
- ☐ Foreign national/*Foreign national*

Indirect contributor
Indirect contributor

- ☐ Listahanan
  Listahanan
- ☐ 4Ps/MCCT
  4Ps /MCCT
- ☐ Nakatatandang mamamayan
  Senior Citizen (RA 10645)
- ☐ PAMANA
  PAMANA
- ☐ KIA/KIPO
  KIA/KIPO
- ☐ Bangsamoro/Normalization
- ☐ Inisponsuran ng LGU
  LGU-sponsored
- ☐ Inisponsuran ng NGA
  NGA-*sponsored*
- ☐ Inisponsuran ng pribadong sector
  Private-sponsored
- ☐ Taong may kapansanan
  Person with disability

Iba pa
Others
☐ Point of Service (POS) Financially Incapable

MASTER COPY 2/19/25 DC:

B. Impormasyong Klinikal ***B. Clinical Information***	
1. Paglalarawan ng kondisyon ng pasyente *Description of condition*	
2. Napagkasunduang angkop na plano ng gamutan sa ospital *Applicable Treatment Plan agreed upon with healthcare provider*	
3. Napagkasunduang angkop na alternatibong plano ng gamutan sa ospital *Applicable alternative Treatment Plan agreed upon with health care provider*	
C. Talatakdaan ng Gamutan at Kasunod na Konsultasyon ***C. Treatment Schedule and Follow-up Visit/s***	
1. Petsa ng unang pagkakaospital o konsultasyon [a] (buwan/araw/taon) *Date of initial admission to HF or consult [a] (mm/dd/yyyy)* [a] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa pagkonsulta para sa rehabilitasyon ng external lower limb pre-prosthesis/ device. Para naman sa PD First, ito ay ang petsa ng konsultasyon o pagdalaw sa PD provider bago magsimula ang unang PD exchange. *[a] For ZMORPH/children with disabilities (CWDs), this refers to the consult prior to the provision of the device and/or rehabilitation. For PD First, this refers to the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange.*	
2. Pansamantalang Petsa ng susunod na pagpapa-ospital o konsultasyon[b] (buwan/araw/taon) *Tentative Date/s of succeeding admission to HF or consult [b] (mm/dd/yyyy)* [b] Para sa ZMORPH/ mga batang may kapansanan, ito ay petsa ng paglalapat at pagsasayos ng device. Para naman sa PD First, ito ay ang kasunod na pagbisita sa PD Provider. *[b] For ZMORPH/CWDS, this refers to the measurement, fitting and adjustments of the device. For the PD First, this refers to the next visit to the PD Provider.*	
3. Pansamantalang Petsa ng kasunod na pagbisita [c] (buwan/araw/taon) *Tentative Date/s of follow-up visit/s [c] (mm/dd/yyyy)* [c] Para sa ZMORPH/ mga batang may kapansanan, ito ay tumutukoy sa rehabilitasyon ng external lower limb post-prosthesis. *[c] For ZMORPH/CWD, this refers to the external lower limb post-prosthesis rehabilitation consult.*	

D. Edukasyon ng Miyembro ***D. Member Education***		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (√) on appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
1. Ipinaliwanag ng kinatawan ng ospital ang uri ng aking karamdaman. *My health care provider explained the nature of my condition/disability.*		
2. Ipinaliwanag ng kinatawan ng ospital ang mga pagpipiliang paraan ng gamutan/interbensyon [d] *My healthcare provider explained the treatment options/intervention[d].* [d] Para sa ZMORPH, ito ay ukol sa pangangailangan ng pagbibigay at rehabilitasyon para sa pre at post-device. *[d] For ZMORPH, this refers to the need for pre- and post-device provision and rehabilitation.*		
3. Ipinaliwanag ng kinatawan ng ospital ang mga posibleng mga epekto/ masamang epekto ng gamutan/ interbensyon. *The possible side effects/adverse effects of treatment/intervention were explained to me.*		
4. Ipinaliwanag ng kinatawan ng ospital ang kailangang serbisyo para sa gamutan ng aking karamdaman/ interbensyon. *My health care provider explained the mandatory services and other services required for the treatment of my condition/intervention.*		
5. Lubos akong nasiyahan sa paliwanag na ibinigay ng ospital. *I am satisfied with the explanation given to me by my health care provider*		
6. Naibigay sa akin nang buo ang impormasyon na ako ay mahusay na aalagaan ng mga dalubhasang doktor sa aking piniling kinontratang ospital ng PhilHealth at kung gustuhin ko mang lumipat ng ospital ay hindi ito maka-aapekto sa aking pagpapagamot. *I have been fully informed that I will be cared for by all the pertinent medical and allied specialties, as needed, present in the PhilHealth contracted HF of my choice and that preferring another contracted HF for the said specialized care will not affect my treatment in any way.*		
7. Ipinaliwanag ng kinatawan ng ospital ang kahalagahan ng pagsunod sa panukalang gamutan/interbensyon. Kasama rito ang pagkompleto ng gamutan/interbensyon sa unang ospital kung saan nasimulan ang aking gamutan/interbensyon. *My health care provider explained the importance of adhering to my treatment plan/intervention. This includes completing the course of treatment/intervention in the contracted HF where my treatment/intervention was initiated.* Paalala: Ang hindi pagsunod ng pasyente sa napagkasunduang gamutan/interbensyon sa ospital ay maaaring magresulta sa hindi pagbabayad ng mga kasunod na claims at hindi dapat itong ipasa bilang case rates. *Note: Non-adherence of the patient to the agreed treatment plan/intervention in the HF may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		

Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol Put a check mark(√) on appropriate answer or NA if not applicable.	OO YES	HINDI NO
8. Binigyan ako ng ospital ng talaan ng mga susunod kong pagbisita. *My health care provider gave me the schedule/s of my follow-up visit/s.*		
9. Ipinaalam sa akin ng ospital ang impormasyon tungkol sa maaari kong hingan ng tulong pinansiyal o ibang pang suporta, kung kinakailangan. a. Sangay ng pamahalaan (Hal.: PCSO, PMS, LGU, etc.) b. Civil society o non-government organization c. Patient Support Group d. Corporate Foundation e. Iba pa (Hal. Media, Religious Group, Politician, etc.) *My health care provider gave me information where to go for financial and other means of support, when needed.* *a. Government agency (ex. PCSO, PMS, LGU, etc.)* *b. Civil society or non-government organization* *c. Patient Support Group* *d. Corporate Foundation* *e. Others (ex. Media, Religious Group, Politician, etc.)*		
10. Nabigyan ako ng kopya ng listahan ng mga kinontratang ospital para sa karampatang paggagamot ng aking kondisyon o karamdaman. *I have been furnished by my health care provider with a list of other contracted HFs for the specialized care of my condition.*		
11. Nabigyan ako ng sapat na kaalaman hinggil sa benepisyo at tuntunin ng PhilHealth sa pagpapa-miyembro at paggamit ng benepisyong naaayon sa Z benefits: *I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits:* a. Kaalipikado ako sa mga itinakdang batayan para sa aking kondisyon/kapansanan. *I fulfill all selections criteria for my condition/disability.*		
b. Ipinaliwanag sa akin ang polisiya hinggil sa "No Balance Billing" (NBB) *The "no balance billing" (NBB) policy was explained to me.* Paalala: Ang polisiya ng NBB ay maaaring makamit ng mga sumusunod na miyembro at kanilang kalipikadong makikinabang kapag na-admit sa ward ng ospital: inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC). *Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.*		
Para sa inisponsuran, maralita, kasambahay, senior citizens at miyembro ng iGroup na may kaukulang Group Policy Contract (GPC) at kanilang kwalipikadong makikinabang, sagutan ang c, d at e.		

For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer c, d and e. c. Nauunawaan ko na sakaling hindi ako gumamit ng NBB ay maaari akong magkaroon ng kaukulang gastos na aking babayaran. *I understand that I may choose not to avail of the NBB and may be charged out of pocket expenses*		
d. Sakaling ako ay nagpalipat sa mas magandang kuwarto ayon sa aking kagustuhan o tumanggap ng karagdagang serbisyo na hindi kasama sa benepisyo, nauunawaan ko na hindi na ako maaaring humiling sa pagamutan para makagamit ng pribilehiyong ibinibigay sa mga pasyente na NBB (kapag NBB, wala nang babayaran pa pagkalabas ng pagamutan) *In case I choose to upgrade my room accommodation or avail of additional services that are not included in the benefit package, I understand that I can no longer demand the hospital to grant me the privilege given to NBB patients (that is, no out of pocket payment upon discharge from the hospital)*		
e. Ninanais ko na lumabas sa polisiyang NBB ang PhilHealth at dahil dito, babayaran ko ang anumang halaga na hindi sakop ng benepisyo sa PhilHealth *I opt out of the NBB policy of PhilHealth and I am willing to pay on top of my PhilHealth benefits* f. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa: *I agree to pay as much as PHP _____* for the following:* ☐ Paglipat ko sa mas magandang kuwarto, o *I choose to upgrade my room accommodation, or* ☐ anumang karagdagang serbisyo, tukuyin _____ *additional services, specify* _____ * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.* * Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy.		

For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy.		
Ang mga sumusunod na katanungan ay para sa mga miyembro ng formal at informal economy at kanilang mga kalipikadong makikinabang ***The following are applicable to formal and informal economy and their qualified dependents*** g. Naiintindihan ko na maaari akong magkaroon ng babayaran para sa halagang hindi sakop ng benepisyo sa PhilHealth. *I understand that there may be an additional payment on top of my PhilHealth benefits.* h. Pumapayag akong magbayad ng hanggang sa halagang PHP _____* para sa aking gamutan na hindi sakop ng benepisyo ng PhilHealth. *I agree to pay as much as PHP _____* as additional payment on top of my PhilHealth benefits.* * Ito ay tinantiyang halaga lamang na gagabay sa pasyente kung magkano ang kanyang babayaran at hindi dapat gawing batayan para sa pagtutuos ng kuwenta ng nagugol na gastusin sa pagkakaospital na babayaran ng PhilHealth. *This is an estimated amount that guides the patient on how much the out of pocket may be and should not be a basis for auditing claims reimbursement.* * Para sa Z Benefits Package ng Breast Cancer, ang halaga ng babayaran ng pasyente ay base lamang sa yugto ng paggamot batay sa plano ng gamutan ng MDT. Walang dagdag bayad para sa benepisyo ng targeted therapy. *For the Z Benefits Package for Breast Cancer, the co-payment of the patient shall be based per treatment phase in accordance with the agreed treatment plan of the MDT. No-copayment shall be applicable for benefits under targeted therapy.*		
12. Limang (5) araw lamang ang babawasan mula sa 45 araw na palugit sa benepisyo sa isang taon para sa buong gamutan sa ilalim ng Z benefits*. *Only five (5) days shall be deducted from the 45 confinement days benefit limit per year for the duration of my treatment/intervention under the Z Benefits.* **Not applicable for the Z Benefits for Peritoneal Dialysis, Kidney Transplantation, Open Heart Surgeries (CABG, VSD, TOF and Heart Valve Surgery)*		

E. Tungkulin at Responsabilidad ng Miyembro *E. Member Roles and Responsibilities*		
Lagyan ng (√) ang angkop na sagot o NA kung hindi nauukol *Put a (√) on appropriate answer or NA if not applicable*	OO *YES*	HINDI *NO*
1. Nauunawaan ko ang aking tungkulin upang masunod ang nararapat at nakatakda kong gamutan. *I understand that I am responsible for adhering to my treatment schedule.*		
2. Nauunawaan ko na ang pagsunod sa itinakdang gamutan ay mahalaga tungo sa aking paggaling at pangunahing kailangan upang magamit ko nang buo ang Z benefits. *I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.*		
3. Nauunawaan ko na tungkulin kong sumunod sa mga polisiya at patakaran ng PhilHealth at ospital upang magamit ang buong Z benefit package. Kung sakali na hindi ako makasunod sa mga polisiya at patakaran ng PhilHealth at ospital, tinatalikuran ko ang aking pribilehiyong makagamit ng Z benefits. *I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.*		

F. Pangalan, Lagda, Thumb Print at Petsa *F. Printed Name, Signature, Thumb Print and Date*		
Pangalan at Lagda ng pasyente:* *Printed name and signature of patient** *Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb Print (kung hindi makakasulat ang pasyente) *(if patient is unable to write)*	Petsa (buwan/ araw/ taon)
Pangalan at lagda ng nangangalagang Doktor: *Printed name and signature of Attending Doctor*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Mga Saksi: *Witnesses:*		
Pangalan at lagda ng kinatawan ng ospital: *Printed name and signature of HF staff member*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Pangalan at lagda ng asawa/ magulang / pinakamalapit na kamag-anak/awtorisadong kinatawan *Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative* × walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*

MASTER COPY 2/19/25

G. Detalye ng Tagapag-ugnay ng PhilHealth para sa Z benefits *G. PhilHealth Z Coordinator Contact Details*		
Pangalan ng Tagapag-ugnay ng PhilHealth para sa Z benefits na nakatalaga sa ospital *Name of PhilHealth Z Coordinator assigned at the HF*		
Numero ng Telepono *Telephone number*	Numero ng CellPhone *Mobile number*	Email Address

H. Numerong maaaring tawagan sa PhilHealth *H. PhilHealth Contact Details*
Opisinang Panrehiyon ng PhilHealth _____ *PhilHealth Regional Office No.* Numero ng telepono _____ *Hotline Nos.*

I. Pahintulot sa pagsusuri sa talaan ng pasyente ***I. Consent to access patient record***	J. Pahintulot na mailagay ang *medical data* sa Z benefit information and tracking system (ZBITS) ***J. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)***
Ako ay pumapayag na suriin ng PhilHealth ang aking talaang medikal upang mapatunayan ang katotohanan ng Z-claim *I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the Z-claim*	Ako ay pumapayag na mailagay ang aking impormasyong medikal sa ZBITS na kailangan sa Z benefits. Pinahihintulutan ko din ang PhilHealth na maipaalam ang aking personal na impormasyong pangkalusugan sa mga kinontratang ospital. *I consent to have my medical data entered electronically in the ZBITS as a requirement for the Z Benefits. I authorize PhilHealth to disclose my personal health information to its contracted partners*

MASTER COPY 9/19/25 Date: _____

Ako ay nagpapatunay na walang pananagutan ang PhilHealth o sinumang opisyal, empleyado o kinatawan mula sa pahintulot na nakasaad sa itaas sapagkat kusang-loob ko itong ibinigay upang makagamit ng Z benefits ng PhilHealth.

I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.

Buong pangalan at lagda ng pasyente* *Printed name and signature of patient** * Para sa mga menor de edad, ang magulang o tagapag-alaga ang pipirma o maglalagay ng thumb print sa ngalan ng pasyente. * *For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.*	Thumb print (Kung hindi na makasusulat) *(if patient is unable to write)*	Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Buong pangalan at lagda ng kumakatawan sa pasyente *Printed name and signature of patient's representative* ☐ walang kasama/ *no companion*		Petsa (buwan/araw/taon) *Date (mm/dd/yyyy)*
Relasyon ng kumakatawan sa pasyente (Lagyan ng tsek ang angkop na kahon) *Relationship of representative to patient (tick appropriate box)* ☐ asawa *spouse* ☐ magulang *parent* ☐ anak *child* ☐ kapatid *next of kin* ☐tagapag-alaga *guardian* ☐ walang kasama *no companion*		

PhilHealth

Benefits

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly health facility or you may contact PhilHealth call center at 8662-2588. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:
- ☐ Acute lymphoblastic leukemia
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Kidney transplantation
- ☐ Cervical cancer
- ☐ Coronary artery bypass surgery
- ☐ Surgery for Tetralogy of Fallot
- ☐ Surgery for ventricular septal defect
- ☐ ZMORPH/Expanded ZMORPH
- ☐ Post kidney transplantation services
- ☐ Orthopedic implants
- ☐ Peritoneal dialysis
- ☐ Colorectal cancer
- ☐ Prevention of preterm delivery
- ☐ Preterm and small baby
- ☐ Children with developmental disability
- ☐ Children with mobility impairment
- ☐ Children with visual disability
- ☐ Children with hearing impairment
- ☐ Heart valve repair and/or replacement for valvular heart disease

2. Respondent's age is:
- ☐ 19 years old & below
- ☐ between 20 to 35
- ☐ between 36 to 45
- ☐ between 46 to 55
- ☐ between 56 to 65
- ☐ above 65 years old

3. Sex of respondent
- ☐ male
- ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the health facility (HF) in terms of availability of medicines or supplies needed for the treatment of your condition?
- ☐ adequate
- ☐ inadequate
- ☐ don't know

5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
☐ excellent
☐ satisfactory
☐ unsatisfactory
☐ don't know

6. In general, how would you rate the health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
☐ excellent
☐ satisfactory
☐ unsatisfactory
☐ don't know

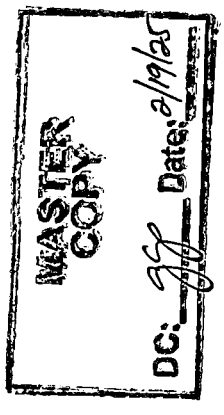
7. In your opinion, by how much has your HF expenses been lessened by availing of the Z benefit package?
☐ less than half
☐ by half
☐ more than half
☐ don't know

8. Overall patient satisfaction (PS mark) is:
☐ excellent
☐ satisfactory
☐ unsatisfactory
☐ don't know

9. If you have other comments, please share them below:

_____
_____
_____

Thank you. Your feedback is important to us!



_____
Signature of Patient/ Parent/ Guardian

Date accomplished: _____

Annex F: Checklist of Requirements for Reimbursement

PhilHealth
Your Partner in Health

BAGONG PILIPINAS

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT FOR HEART VALVE REPAIR AND/OR REPLACEMENT FOR VALVULAR HEART DISEASE

Requirements	Remarks
1. Transmittal Form (Annex G)	
2. Checklist of Requirements for Reimbursement (Annex F)	
3. Photocopy of approved Pre –Authorization Checklist & Request ☐ Annex A.1: Pre-authorization Checklist and Request Form for Heart Valve Replacement for Valvular Heart Disease (Adult) ☐ Annex A.2: Pre-authorization Checklist and Request Form Heart Valve Repair and/or Replacement for Valvular Heart Disease (Pedia)	[redacted]
4. Photocopy of completely accomplished ME Form (Annex D)	
5. Properly accomplished PhilHealth Claim Form (CF) 1 OR PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Completed Checklist of Essential Health Services (Annex H)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex E)	
8. Original or Certified true copy of Statement of Account (SOA)	
9. Photocopy of accomplished surgical operative report	
10. Photocopy of accomplished anesthesia report	
Date Filed (mm/dd/yyyy):	

MASTER COPY
DC: Date: 2/19/25

SOCOTEC ISO 9001 PAB

HEALTH FACILITY (HF)		
ADDRESS OF HF		
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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, Suffix, Middle Name	
	2. PhilHealth ID Number ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Cardiologist (Adult or Pediatric)	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No.	PhilHealth Accreditation No.
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient
Date signed (mm/dd/yyyy)

MASTER COPY
DC: Date: 2/19/25

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PhilHealth *Your Partner in Health*

BAGONG PILIPINAS

TRANSMITTAL FORM

NAME OF CONTRACTED HEALTH FACILITY	ADDRESS OF HF

Instructions for filling out this Transmittal Form. Use additional sheets if necessary.

1. Use CAPITAL letters or UPPER CASE letters in filling out the form.
2. For the period of confinement, follow the format (mm/dd/yyyy).
3. For the Z Benefits Package Code, indicate the code based on the services provided. Example: Z030A
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth..

MASTER COPY Date: 2/19/25

	Case Number	Name of Patient (Last, First, Middle Initial, Extension)	Period of Confinement		Z Benefits Package Code	Remarks
			Date admitted	Date discharged		
1.						
2.						
3.						
4.						
5.						
6.						
7.						

Certified correct by authorized representative of the HF		For PhilHealth Use Only	Initials	Date
	Designation	Received by Local Health Insurance Office (LHIO)		
Printed Name and Signature	Date signed (mm/dd/yyyy)	Received by the Benefits Administration Section (BAS)		

SOCOTEC ISO 9001 PAB

Annex H: Checklist of Essential Health Services

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

Case No. _____

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

CHECKLIST OF ESSENTIAL HEALTH SERVICES FOR HEART VALVE REPAIR AND/OR REPLACEMENT FOR VALVULAR HEART DISEASE

Type of Procedure or Service
Place a (✔) on the type of procedure or service; and whether adult or pediatric as applicable

- ☐ Mitral Valve Replacement with Tricuspid Valve Annuloplasty ___ Adult ___ Pediatric
- ☐ Aortic Valve Replacement with Tricuspid Valve Annuloplasty (Pediatric)
- ☐ Mitral Valve Replacement ___ Adult ___ Pediatric
- ☐ Aortic Valve Replacement (Pediatric)
- ☐ Mitral and Tricuspid Valve Repair (Pediatric)
- ☐ Mitral Valve Repair (Pediatric)
- ☐ Aortic Valve Repair (Pediatric)
- ☐ Cardiac Rehabilitation (minimum of 4 sessions) ___ Adult ___ Pediatric

MASTER COPY 9/19/25

I. Laboratory Tests and Diagnostics
Place a (✔) opposite appropriate answer; as applicable

***Mandatory**	___ Creatinine
___ CBC with platelet	___ Albumin
___ Blood typing	___ BUN
___ Prothrombin time	___ Urinalysis
___ Activated partial thromboplastin time	___ Chest X-ray (PA lateral)
	___ 12 lead ECG
Electrolytes :	___ Arterial blood gas (ABG)
___ Sodium (Na)	___ CBG monitoring
___ Potassium (K)	___ 2DEcho with Doppler (transthoracic or

___ Ionized Calcium (iCa) ___ Magnesium (Mg) ___ Chloride (Cl)	transesophageal), intra-op transesophageal echo
***As indicated** ___ SGPT ___ SGOT	

II. Treatment and Medications	Place a (✔) opposite appropriate answer; as applicable
***Mandatory** ___ Incentive spirometry ___ Blood products screening ___ Nebulization	___ Mechanical ventilator use ___ Beta blockers specify: _____ ___ Anticoagulant specify:
***As indicated:** ___ Antiplatelet specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Statin specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Antimicrobials specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Phenoxymethylpenicillin	☐ Contraindicated ☐ Will cause adverse reaction
___ ACE inhibitors or ARB specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Sedation/pain specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ GI medicine specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Pulmonary medicine specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Hemodynamic support specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Electrolytes specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Calcium channel blockers specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
___ Digoxin specify: _____	☐ Contraindicated ☐ Will cause adverse reaction
Others specify: _____	

Place a (✔) in the appropriate tick box if the service is done or given		
III. Procedure Place a (✔) if the service(s) is/are done or given		**IV. Cardiac Rehabilitation Services** Place a (✔) on the appropriate tick box
Heart valve surgery		☐ Adult ☐ Pedia *Maximum of 4 sessions (Daily Assessment, Pre-rehabilitation Orientation, and Post-rehabilitation discharge instructions)
Immediate Postoperative Care at Surgical ICU (SICU)		
For heart valve replacement (mechanical valve) ☐ Prosthetic mitral valve ☐ Prosthetic aortic valve		Indicate the dates of availment of cardiac rehabilitation services (mm/dd/yyyy): Date of 1st Session: _____ ☐ Inpatient ☐ Outpatient Date of 2nd Session: _____ ☐ Inpatient ☐ Outpatient Date of 3rd Session: _____ ☐ Inpatient ☐ Outpatient Date of 4th Session: _____ ☐ Inpatient ☐ Outpatient
Applicable for heart valve replacement with tricuspid annuloplasty: Prosthetic mitral or aortic valve (mechanical valve) + Tricuspid annuloplasty ring		

Certified correct by:	Conforme by:
(Printed name and signature) **Tick the appropriate attending physician** ☐ Cardiologist or Cardiovascular Surgeon* ☐ Cardiac Rehabilitation or Physical Medicine and Rehabilitation Specialists/ Physiatrist*	(Printed name and signature) ☐ Patient ☐ Parent ☐ Guardian
PhilHealth Accreditation No:	
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

MASTER COPY
DC: Date: 2/19/23