Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PHILHEALTH CIRCULAR
No. 2025 - 0012

TO : **ALL CONTRACTED HEALTH FACILITIES FOR THE Z BENEFITS PACKAGE FOR POST-KIDNEY TRANSPLANTATION SERVICES AND ALL OTHERS CONCERNED**

SUBJECT : **Z Benefits Package for Post-Kidney Transplantation Services in Adults**

I. RATIONALE

Chronic kidney disease (CKD) is a pressing global health issue, with prevalence of 9.1% to 13.4% of the population worldwide.[1] In the Philippines, its prevalence is 35.94%, which is much higher than estimated global rates.[2] According to the National Kidney and Transplant Institute (NKTI), one Filipino develops chronic kidney failure every hour, equating to around 120 new cases per million population annually.

In 2012, PhilHealth launched a comprehensive benefits package for kidney transplantation (low risk) under the Z Benefits. With the enactment of the Republic Act (R.A.) No. 11223, also known as the Universal Health Care Act (UHC Act), portions of the funds from the Philippine Amusement and Gaming Corporation (PAGCOR) and Philippine Charity Sweepstakes Office (PCSO) shall be transferred to PhilHealth for the improvement of benefits packages.

Kidney transplantation[3] is the gold standard treatment option of renal replacement therapy for patients with chronic kidney disease stage 5 (CKD5) as it can extend life expectancy and improve quality of life. However, despite the advantages of kidney transplantation, the patient will require long-term support in managing organ rejection. A comprehensive benefits package designed for post-kidney transplantation services will support patients in managing the chronic care of kidney transplantation, reduce complications, minimize the risk of organ rejection, and increase survival rates.

Thus, the PhilHealth Board of Directors, through PhilHealth Board Resolution No. 2965 s. 2024[4], approved the implementation of the benefits package for post-kidney transplantation services to help reduce the financial burden on

[1]https://pmc.ncbi.nlm.nih.gov/articles/PMC9073222/
[2]https://pmc.ncbi.nlm.nih.gov/articles/PMC8880400/#pone.0264393.ref002
[3]https://pubmed.ncbi.nlm.nih.gov/37955463/
[4]PhilHealth Board Resolution No. 2965 s. 2024: Resolution approving the Post-Kidney Transplantation Services

patients and their families, promote better health outcomes, and support the broader goal of improving access to quality healthcare for all Filipinos.

II. OBJECTIVES

This PhilHealth Circular aims to expand the coverage for kidney transplantation to cover post-kidney transplantation services and ensure equitable access to quality healthcare services and financial risk protection.

III. SCOPE

This PhilHealth Circular covers the provision of comprehensive health care services for pediatric kidney transplant recipients and kidney donors under the Z Benefits Package. This Circular shall apply to all contracted health facilities (HFs) and all others involved in the implementation of the Z Benefits package for post-kidney transplantation services for adult patients.

IV. DEFINITION OF TERMS

A. Balance Billing[5] – additional payments by insured patients on top of the amount paid by insurance when the provider's charges exceed the amount covered by health insurance. Due to financial and service coverage decisions, balance billing may result in increased financial burdens and limited access to health services by households.

B. Chronic Kidney Disease Stage 5 (CKD5) – end-stage renal disease (ESRD) or an advanced stage of kidney disease resulting in irreversible loss of nearly all ability to remove toxic by-products from the blood.

C. Contracted Health Facility (HF)[6] – any health facility that enters into a contract with the Corporation for the provision of specialized care.

D. Copayment – a flat fee or predetermined rate paid at a point of service, as may be determined by PhilHealth. This amount will be charged to patients as their share for amenities, choice of physician, specialist fees for private patients, or upgrade of services beyond the coverage of the benefits package. Copayments shall have a fixed limit or cap not exceeding the corresponding rate of the Z Benefits package. These copayment rates shall be subject to negotiation by PhilHealth and stipulated in the contract to determine the applicable rates and ensure financial risk protection for the beneficiaries.

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

F. Eligibility Criteria – a set of requirements to determine if an individual is qualified to avail of the benefits package.

[5]PC No. 2024-0023: Institutionalization of 156 Hemodialysis Sessions and Coverage Expansion (Revision 2)
[6]PC No. 2022-0012: Contracting of a Health Facility as a Z Benefit Provider (Revision 1)

G. **Essential Health Services** – a set of identified services that PhilHealth covers for which HFs must provide based on clinical practice guidelines (CPG) and/or expert consensus as approved by the Corporation.

H. **Lost to Follow-up** – a term used to characterize a patient who has not returned to or followed up at a contracted health facility after sixty (60) calendar days from the scheduled visit or treatment, as advised.

I. **Member Empowerment Form (ME Form)** – a document showing that the patient is fully informed of their Z Benefits 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.

J. **Post-Kidney Transplantation Passport** – a document or record that serves as a source of data on the prescribed medications, treatment schedule, date of dispensing of the medication, inclusive dates, laboratory/diagnostic tests conducted to patients. This shall also serve as a source of data during patient transfer, claims payment, and monitoring.

K. **Renal Replacement Therapy** – kidney replacement therapy which is a medical treatment that replaces the normal kidney function in patients with acute or chronic kidney failure. It involves using various techniques, such as hemodialysis, peritoneal dialysis, and kidney transplantation, to remove waste products, excess fluids, and electrolytes from the bloodstream.

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. This benefits package covers the essential health services for kidney transplant patients needing immunosuppressive medicines, routine laboratory and diagnostic tests, procedure, follow-up consultations, and monitoring of organ donors.

3. The selection criteria are detailed in the Pre-authorization Checklist and Request Forms for KT Recipient (Annex A.1.) and living kidney donor (Annex A.2), which shall serve as the basis for PhilHealth's approval. Once approved, the contracted HF shall provide the covered essential health services under this benefits package. The approved pre-authorization shall be valid for a period of one hundred eighty (180) calendar days from the date of approval.

4. 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 Post-Kidney Transplantation Services in Adults).

5. The contracted HF shall submit the following documents to the nearest Local Health Insurance Office (LHIO) or PhilHealth Regional Office-Benefits Administration Office (PRO-BAS) that has jurisdiction over the contracted HF:

   a. For kidney transplant recipient:
      a.1. Original copy of the Pre-authorization Checklist and Request Form (Annex A.1.);
      a.2. Photocopy of the Member Empowerment (ME) Form (Annex D); and
      a.3. Photocopy of the treatment plan.

   b. For living kidney donor:
      b.1. Original copy of the Pre-authorization Checklist and Request Form (Annex A.2.).

   The original copies of these documents shall be attached to the patient's record and be readily accessible for verification during the monitoring and evaluation of the benefits package.

6. Pre-authorization approval is a one-time process in which eligible patients may continuously avail of the essential health services under this benefits package, except when declared lost to follow-up or have expired.

7. KT recipients receiving immunosuppressive medicines may continue their remaining medical management for any services covered under this benefits package. The attending physician shall prescribe a treatment plan for continuity of care.

8. The forty-five (45) day annual benefit limit shall not apply when a patient avails of this benefits package, following the existing guidelines[7] of the Corporation.

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

10. The contracted HF shall not charge any copayment on the essential health services covered in this Z Benefits package.

11. The contracted HF may charge copayment or out-of-pocket (OOP) expenses for amenities, choice of physician, specialist fees for private patients, or upgrade of health services that are not covered by the Z Benefits package. This copayment is mutually agreed upon by the patient and contracted HFs during the discussion of the ME Form for services

[7]PhilHealth Circular No. 2025-0007 "Lifting the 45-Day Benefit Limit Rule"

beyond the scope of essential health services. Such copayment shall be payable at the point of service of the patient's treatment or service availed.

12. Patients who were declared lost to follow-up but intend to continue availing of the essential health services shall be required to undergo pre-authorization and approval for re-enrolment in the benefits package. The contracted HF can provide these health services upon approval of the pre-authorization.

13. Patients who are not yet declared lost to follow-up and returned within sixty (60) days from the advised scheduled visit or treatment may continue availing of the benefits package under the Z Benefits.

14. Any proposal for PhilHealth coverage to include new technologies, such as drugs/medicines and biologicals not listed in the latest Philippine National Formulary (PNF), diagnostic procedures, surgical interventions, and other treatment interventions shall consider the Health Technology Assessment Council (HTAC) recommendation.

B. Responsibilities of the Contracted Health Facilities

1. The contracted HF shall adhere to the selection criteria for all kidney transplant recipients and kidney donors availing of this benefits package.

2. The attending physician for kidney transplant recipients and living kidney donor shall be any of the following:

   a. Nephrologist
   b. Transplant Surgeon

3. The contracted HF shall develop a treatment plan for at least six (6) months, detailing the schedule of follow-up appointments, laboratory or diagnostic tests, immunosuppressive medications, other therapies, and surgeries, if applicable, including evaluation of overall health conditions. The treatment plan shall be updated and made available in the patient's record for purposes of monitoring and post-audit.

4. The attending physician shall prescribe the medications for the patient. If the patient fails to return on the scheduled follow-up date, the next prescription and dispensing of medicines shall start from the actual date of their return. Any medicine supplies that were missed during the patient's absence shall not be provided retroactively.

5. The licensed pharmacist shall verify the prescription and supervise the dispensing of medications. The patient must receive clear instructions regarding dosage, frequency of drug administration, and potential side effects.

6. In case of changes of prescription of immunosuppressive medicines, the contracted HF shall attach an updated treatment plan reflecting the

changes or adjustments in the patient's management to be signed by the attending physician when submitting the claims.

7. The prescription period of medications shall not overlap with any prior or subsequent prescriptions to ensure accurate claims processing and prevent duplication.

8. In cases of holidays, weekends, or fortuitous events, the contracted HFs shall develop their internal guidelines on prescribing and dispensing medications to ensure continuous treatment of the patient.

9. The contracted HF shall monitor their patients for any adverse drug reactions, compliance to treatment regimen, and overall health status.

10. The attending physician shall refer their patients for further medical evaluation to the appropriate medical specialist if needed.

11. If a patient transfers or relocates to another place or region, the referral of the patient shall be coordinated to the nearest contracted facility in the region, as applicable.

12. All contracted HFs shall submit a renal allograft pre-biopsy report or its equivalent for KT recipients availing of the renal graft biopsy via email to the designated PhilHealth Regional Office (PRO) within three (3) days after the procedure. Late submission of the report shall not be a ground for denial of the claims. The PhilHealth Regional Office - Benefits Administration Section (PRO-BAS) shall keep the electronic copy of the report submitted by contracted HFs and transmit these documents to the Benefits Development and Research Department.

13. The contracted HF shall submit the renal allograft biopsy result or its equivalent as an attachment to the claims for renal graft biopsy.

14. The contracted HF shall document the health services provided to the patient in the Checklist of Essential Health Services (Annex E). The required signatories shall affix their signatures to attest that the health services were rendered to the patient.

15. The contracted HF shall provide a Post-Kidney Transplant (Post-KT) Passport (Annex F) to their patients. The attending physician or authorized personnel is responsible for recording prescribed and dispensed medicines, laboratory tests and diagnostic procedures, and consultations in the Post-KT Passport. This document serves as a log of services received by patients under the Z Benefits package for post-KT services.

16. The contracted HFs shall require patients to be physically present when collecting medications, as applicable. In case of patient's absence, the contracted HFs shall require any of the following:

a. Original or certified true copy (CTC) of medical certificate, medical abstract, or similar documents for hospitalized patients
b. Live video conference with the patient
c. Recent photograph of the patient holding a newspaper or beside the television displaying the date within two (2) days prior to collecting medications

17. 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.

18. While PhilHealth is developing a system for electronic Post-KT Passport, the attending physician or authorized personnel shall record all medications, laboratory, and diagnostic tests manually in the Post-KT Passport.

19. The contracted HFs must appoint at least one (1) Z Benefits Coordinator whose responsibilities are outlined in the PhilHealth Circular (PC) No. 2021-0022 titled "The Guiding Principles of the Z Benefits (Revision 1)" or based on existing guidelines.

20. The contracted HFs shall maintain a digital or physical copy of all medical records submitted by the patients for monitoring and post-audit purposes by PhilHealth.

21. As stipulated in the RA No. 11223 (Universal Healthcare 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. It is the sole responsibility of the contracted HF to distribute the PF to their health professionals based on their mutual agreements and internal guidelines.

C. Responsibilities of the Patient and their Representatives

1. All enrolled patients shall adhere to the treatment plan and follow-up appointments schedule.

2. All patients shall sign or affix their signature or thumb mark on the documents that require their approval or consent.

3. If a patient's representative will collect medications on behalf of the patient, they must present a Special Power of Attorney (SPA) as proof of authorization.

4. Patients are strictly prohibited from sharing, selling or distributing post KT medications. They shall be aware that the medications given to them are intended for their personal use only.

5. Patients found liable for selling their post KT medications shall forfeit all the privileges of availing benefits under Z, without prejudice to the filing of

appropriate charges for possible violation in accordance with the existing laws, rules and regulations. This information must be understood and agreed upon by the patient and must be explained clearly by the contracted HF.

D. Patient Transfer

1. The contracted HF shall facilitate a coordinated referral process to ensure compliance to treatment and continuity of care of their patients.

2. Post-KT patients are allowed to transfer from one contracted HF to another after the prescription month. The referring contracted HFs shall coordinate the referral and transfer the patient when accepted by the referral contracted HF.

3. Post-KT patients who are allowed to transfer to another contracted HF shall submit an original copy of the accomplished letter of intent for transfer from their respective contracted HF (Annex G).

4. The referring contracted HF shall facilitate the completion of the letter of intent by seeking clearance from the following:

   a. Nephrologist or transplant surgeon from the referring HF;

   b. Z Benefits Coordinator of the referring HF;

   c. Head/Z Benefits coordinator of the referral HF; and

   d. PRO-BAS that has jurisdiction over the referring contracted HF.

5. The referring contracted HF shall accomplish and submit the required documents specified in the checklist for patient transfer to the referral contracted HF (Annex H) and PRO-BAS that has jurisdiction over the referral contracted HF.

6. The documents for patient transfer may be scanned and emailed to the respective PRO-BAS for their information and acknowledgment.

7. The referring contracted HF shall be paid based on the services rendered to the patient. The required documents for claims filing shall be properly accomplished for submission to PhilHealth.

E. The package codes, rates, and description are as follow:

1. Immunosuppressive Medications

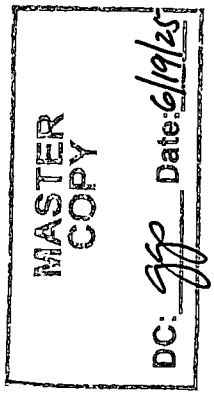
Package Code	Description	Package Rate (PHP)	Filing Period
Z027A*	1. Calcineurin inhibitor (CNI): Tacrolimus Cyclosporine 2. Anti-proliferative: Mycophenolic acid (mycophenolate sodium or mycophenolate mofetil) Azathioprine 3. mTOR: Everolimus Sirolimus 4. Corticosteroids: Prednisone Prednisolone	40,725 per prescription every 30 days	Within 60 days after the date of prescription of the medication
*Any of the following immunosuppression combinations: 1. Calcineurin inhibitors (CNI) + Anti-Proliferative +/- Corticosteroid; OR 2. CNI + mTOR inhibitor +/- Corticosteroid; OR 3. mTOR inhibitors + Anti-Proliferative +/- Corticosteroid.			

Table 1: Package Code, Description, Package Rate, and Filing Period of Immunosuppressive Medications for Adult Patient

2. Drug Prophylaxis

Package Code	Description	Package Rate (PHP)	Filing Period
Z027B	1. Nystatin 2. Valacyclovir or valganciclovir 3. Isoniazid (INH) 4. Cotrimoxazole	18,932 for 6 months prescription	Within sixty (60) days after the 6th month prescription of medication

Table 2: Package Code, Description, Package Rate, and Filing Period of Drug Prophylaxis for Adult Patient



3. Drug Level Monitoring

Package Code	Description	Package Rate (PHP)	Filing Period
Z027C1[a]	Any of the following: a. Tacrolimus (trough) or Cyclosporine (trough or C2 level)	3,100 per availment (31,000 for the initial year)	Within sixty (60) days after completion of the service

Package Code	Description	Package Rate (PHP)	Filing Period
Z027C2[b]	b. Everolimus (trough) or Sirolimus (trough) c. Mycophenolate AUC	3,100 every 3 months (12,400 per succeeding year)	
[a]Maximum availment of 10x ; Applicable to kidney recipients during the first year after the kidney transplant procedure [b]Maximum availment of 4x a year; Applicable to kidney recipients starting from the 13th month after the kidney transplant procedure			

Table 3: Package Code, Description, Package Rate, and Filing Period of Drug level monitoring for Adult Patient

4. Laboratory Tests

Package Code	Description	Package Rate (PHP)	Filing Period
Z027D1[a c]	Laboratory tests (initial year)	11,242 for every 3 months during the initial year (44,968 in the initial year)	Within sixty (60) days after the end of the 3rd month schedule
Z027D2[b c]	Laboratory tests (Succeeding year)	8,125 for every 3 months of the succeeding year (32,500 per year)	
[a]Applicable to kidney recipients during the first year after the kidney transplant procedure [b]Applicable to kidney recipients starting from the 13th month after the kidney transplant procedure [c]Laboratory tests can be prescribed multiple times, subject to the amount limit per claim			

Table 4: Package Code, Description, Package Rate, and Filing Period of Laboratory Tests for Adult Patient

5. Renal Graft Biopsy

Package Code	Description	Package Rate (PHP)	Filing Period
Z027E	Renal graft biopsy	77,000.00 (once a year, if indicated)	Within 60 days after completion of the service

Table 5: Package Code, Description, Package Rate, and Filing Period of Renal Graft Biopsy for Adult

6. Diagnostic Tests

Package Code	Description	Package Rate (PHP)	Filing Period
Z027F	Chest X-ray Whole abdominal ultrasound	4,000.00 (once a year)	Within sixty (60) days after completion of the service
Z027G	Renal graft doppler	3,400.00 (once a year, if needed)	

Table 6: Package Code, Description, Package Rate, and Filing Period of Diagnostic Tests for Adult

7. Living Donor Monitoring

Package Code	Description	Package Rate (PHP)	Filing Period
Z027H*	Creatinine Urinalysis As indicated: Fasting blood sugar (FBS) Random urine total protein:creatinine ratio or random urine albumin:creatinine ratio	1,900 every 6 months (3,800 per year)	Within sixty (60) days after the end of the 6th month schedule
*Laboratory tests can be avail of multiple times, subject to the amount limit per claim			

Table 7: Package Code, Description, Package Rate, and Filing Period of Living Donor Monitoring

F. Claims Filing

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 the beneficiaries. All Z Benefits claims shall be filed by the contracted HF.

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 prior to filing of claims.

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.

5. For patients availing more than one (1) benefits package, the contracted HF shall prepare one (1) CF2 per package code availed of by the patient. In addition, the respective statements of account (SOA) or consolidated SOA shall be attached to the corresponding claims filed to PhilHealth.

6. If the patient died or was declared lost to follow-up, the contracted HF shall file the claims according to the services rendered to the patient.

7. The contracted HFs shall properly indicate the OOP and/or copayment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption Benefits" and in the SOA.

8. The contracted HFs shall follow existing guidelines of the SOA[8] requirement for claims submission under the Z Benefits.

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

10. 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."

    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.

11. The contracted HFs shall exhaust all efforts to contact, navigate, or obtain information about the whereabouts or situation of their patients. In case of patients who are declared lost to follow-up or who expired, the contracted HFs shall file claims based on the applicable scenarios:

    a. The contracted HF shall submit to PhilHealth a notarized sworn declaration that the patient is declared lost to follow-up. The contracted HF shall submit their claims within sixty (60) days from such declaration.

    b. If the patient expired during treatment, the contracted HF shall submit a photocopy of the death certificate or a 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 issued by the authorized government agencies.

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

12. The Z Satisfaction Questionnaire (Annex K) shall be accomplished by all patients enrolled in the Z Benefits and submitted once a year as an additional attachment to claims by 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.

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

14. Existing rules on late filing shall apply. If the delay in the claims filing is due to natural calamities or other fortuitous events, the existing policy of the Corporation on the provisions of special privileges to those affected by fortuitous events shall apply.

G. Claims Payment and Evaluation

1. PhilHealth shall reimburse covered services based on the actual amount reflected in the SOA or its equivalent, except for renal graft biopsy, but the reimbursement shall not exceed the maximum amount specified in the applicable benefits package. Reimbursement for renal graft biopsy shall be based on the predetermined package rates (case-based payment).

2. PhilHealth shall review the completeness of all forms submitted by the contracted HFs. The PROs and Local Health Insurance Offices (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.

3. PhilHealth shall apply the "return to sender (RTS)" policy only for claims documents with incomplete documentary requirements. However, inconsistencies in data or information contained in the documents or non-provision of a mandatory service 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.

4. 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.

5. When the patient expires or is declared lost to follow-up, PhilHealth shall only reimburse the corresponding amount of the services rendered by the contracted HF.

6. Claims for each service within the same date or period shall not be considered overlapping claims.

7. Any change of member/patient category upon enrollment shall not affect the claims filed by the contracted HF.

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

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

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

H. Marketing and Promotion

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

To further widen the reach to the general public, most especially to beneficiaries, PhilHealth likewise encourages contracted health 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. Monitoring

1. PhilHealth shall enforce current policies and guidelines on monitoring the performance of contracted HFs in implementing the Z Benefits package for post-KT services 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 post-KT services, 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.

J. Policy Review

PhilHealth shall conduct a regular policy review of the Z 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.

K. Annexes (Posted on the Official Website of PhilHealth)

Annex A: Pre-authorization Checklist and Request Forms

Annex A.1.: Pre-authorization Checklist and Request Form for Kidney Transplant Recipient - Adult

Annex A.2.: Pre-authorization Checklist and Request Form for Living Kidney Donor

Annex B: Supplementary Rules in Accrediting and Contracting Health Facilities

Annex C: List of Essential Health Services for Post-Kidney Transplantation Services in Adults

Annex D: Member Empowerment Form (ME Form)

Annex E: Checklist of Essential Health Services

Annex E.1.: Checklist of Essential Health Services - Kidney Transplant Recipient - Adult

Annex E.2.: Checklist of Essential Health Services- Living Kidney Donor

Annex F: Post-Kidney Transplant Passport

Annex G: Letter of Intent for Transfer of Care to a Referral Contracted Health Facility

Annex H: Checklist for Patient Transfer to a Contracted HF

Annex I: Checklist of Requirements for Reimbursement

Annex I.1.: Checklist of Requirements for Reimbursement - Kidney Transplant Recipient - Adult

Annex I.2.: Checklist of Requirements for Reimbursement - Living Kidney Donor

Annex J: Transmittal Form

Annex K: Z Satisfaction Questionnaire

VI. PENALTY CLAUSE

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

VII. TRANSITORY CLAUSE

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.

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.

MASTER COPY Date: 6/19/25 DC:

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days after its publication in the Official Gazette or any newspaper of general circulation. Three (3) certified true 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: 06/19/2025

Annex A.1.: Pre-authorization Checklist and Request Form For Kidney Transplant Recipient - 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: ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

(Place a ✔on the appropriate answer)

History of Kidney Transplantation	
☐ Living Organ Donor: ☐ Related ☐ Non-Related	☐ Deceased Organ Donor
Name of the Kidney Transplant Facility: _____	
Address of the Kidney Transplant Facility: _____	
Date of kidney transplantation (mm/dd/yyyy): _____	

Place a check mark (✔) on the appropriate remarks

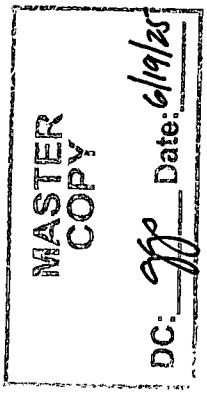
General Criteria	**Remarks**
1. 19 year old and above	☐ Yes
2. Filipino CKD5 patients was transplanted in any DOH licensed transplant facility or PhilHealth accredited health facility	☐ Yes ☐ No
3. If kidney transplantation was performed in a foreign country, the patient (Filipino citizen) submitted both of the following documents: ☐ Medical abstract translated into an English version ☐ Filipino Dual Citizenship Certificate (as applicable)	☐ Yes ☐ NA
4. Ability to follow prescribed medication regimens, particularly immunosuppressive therapy or availability of family or caregiver support in assisting patient's compliance to medical treatment.	☐ Yes
5. If the patient was enrolled in the post-KT services and declared lost to follow-up: Reason/s for lost to follow-up (specify): _____	☐ Yes ☐ NA

MASTER COPY Date: 6/19/25 DC: GJP

Certified correct by:	Conforme by:
(Printed name and signature) Attending Nephrologist/Transplant Surgeon	(Printed name and signature) □ Patient □ Parent □ Guardian
PhilHealth Accreditation No. _____	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. Please do not leave any item blank.



PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy):
This is to request approval for provision of services under the Z Benefits package for _____ 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 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:	Conforme by:
(Printed name and signature) Attending Nephrologist/Transplant Surgeon	(Printed name and signature) □ Patient □ Parent □ Guardian
PhilHealth Accreditation No. _____	PhilHealth Accreditation No. _____

Conforme by:
(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief/ Authorized Signatory
PhilHealth Accreditation No. _____

(For PhilHealth Use Only)

- □ APPROVED
- □ DISAPPROVED (State reason/s) _____

_____

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

MASTER COPY 6/19/25 Laura

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 day			□ Approved □Disapproved		
			Released to HF:		

Annex A.2.: Pre-authorization Checklist and Request Form for Living Kidney Donor

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

(Provide the appropriate answer)

Donor History		
1. Name of the Kidney Transplant Facility:		
2. Address of the Kidney Transplant Facility:		
3. Date of kidney donation (mm/dd/yyyy)		
4. Relationship to the recipient	☐ Related	☐ Non-Related
5. Laterality of donated kidney	☐ Right	☐ Left

Certified correct by:	Conforme by:
(Printed name and signature) Nephrologist	(Printed name and signature) □ Patient □ Parent □ Guardian
PhilHealth Accreditation No. _____	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. Please do not leave any item blank.

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DC: Date: 6/19/25

PRE-AUTHORIZATION REQUEST

DATE OF REQUEST (mm/dd/yyyy):
This is to request approval for provision of services under the Z Benefits package for _____ in _____ (Patient's last, first, suffix, middle name) (Name of contracted HF) 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:	Conforme by:
(Printed name and signature) Nephrologist	(Printed name and signature) □ Patient □ Parent □ Guardian
PhilHealth Accreditation No. _____	

MASTER COPY Date: 6/19/25 DC: ___

Conforme by:
(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/Medical Center Chief/ Authorized Signatory
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) _____ (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			□ Approved □Disapproved		
			Released to HF:		

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(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 Post-Kidney Transplantation Services. 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 per service.

3. The accredited HFs shall submit co-payment proposals to PhilHealth. They shall identify the amenities, choice of physician, 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.

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List of Essential Health Services for Post-Kidney Transplantation Services in Adults

A. For Kidney transplant recipients

Descriptions	Essential Health Services
1. Immunosuppressive Medications (as prescribed)	a. Calcineurin inhibitor (CNI): • Tacrolimus • Cyclosporine (ciclosporin) b. Anti-proliferative: • Mycophenolic acid (mycophenolate sodium or mycophenolate mofetil) • Azathioprine c. mTOR: • Everolimus • Sirolimus d. Corticosteroids: • Prednisone • Prednisolone
2. Antibiotic Prophylaxis (as prescribed)	As prescribed: a. Nystatin for 1 month only b. Valacyclovir (valaciclovir) for 3 months, or valganciclovir, if indicated c. Isoniazid (INH) for 6 months d. Cotrimoxazole for 3 months
3. Drug Level Monitoring (as prescribed)	Any of the following: a. Tacrolimus trough b. Cyclosporine trough or 2-hour post dose (C2) c. Sirolimus trough d. Everolimus trough

Descriptions	Essential Health Services
4. Laboratory Tests	As prescribed: a. Complete blood count (CBC) b. Creatinine c. Sodium (Na) d. Potassium (K) e. Fasting blood sugar (FBS) f. Serum glutamic pyruvic transaminase (SGPT) g. Urinalysis h. Urine total protein creatinine ratio (UTPCR) or Urine albumin creatinine ratio (UACR) i. Lipid profile: • Total cholesterol • High-density lipoprotein (HDL) cholesterol • Low-density lipoprotein (LDL) cholesterol • Triglycerides As indicated: a. Albumin b. Prothrombin time (PT) c. Partial thromboplastin time (PTT) d. HbA1c
5. Procedure	Renal graft biopsy (inclusive of procedure fees and specialist fees)
6. Diagnostic Tests	a. Chest X-ray b. Whole abdominal ultrasound As indicated: Renal graft doppler

B. For Living Kidney Donor Monitoring

Descriptions	Essential Health Services
1. LaboratoryTests	a. Creatinine b. Urinalysis As indicated: a. Fasting blood sugar b. Random urine total protein:creatinine ratio or random urine albumin:creatinine ratio

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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.

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

SOCOTEC ISO 9001
PAB

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

- ☐ Empleyado ng pribadong sektor
  Employed private
- ☐ Empleyado 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
- ☐ Inisponsuran ng LGU
  LGU-sponsored
- ☐ Inisponsuran ng NGA
  NGA-*sponsored*
- ☐ Inisponsuran ng pribadong sektor
  Private-sponsored
- ☐ Taong may kapansanan
  Person with disability

MASTER COPY Date: 6/19/25 DC:

A. Member/Patient Information

☐ Bangsamoro/Normalization

Iba pa
Others

☐ Point of Service (POS) Financially Incapable

D. Member Education

Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (√) on the 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 in denial of filed claims for the succeeding tranches and which should not be filed as case rates.*		

D. Member Education		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (√) on the 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.		

D. Member Education		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (√) on the appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
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.*		

D. Member Education		
Lagyan ng tsek (√) ang angkop na sagot o NA kung hindi nauukol *Put a check mark (√) on the appropriate answer or NA if not applicable.*	OO *YES*	HINDI *NO*
* 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 kwalipikadong benepisyaryo ***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.*		

E. Member Roles and Responsibilities

Lagyan ng (√) ang angkop na sagot o NA kung hindi nauukol *Put a (√) on the 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. 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 thumbprint 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)*

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F. Printed Name, Signature, Thumb Print and Date	
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)*

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. 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*
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.*	

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)***	
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*		

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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 Essential Health Services - Kidney Transplant Recipient - Adult

Place a (✔) in the appropriate tick box if the service is done or given.

Immunosuppressive Medications*			
Description	Date dispensed (mm/dd/yyyy)		
Calcineurin inhibitor (CNI): □ Tacrolimus □ Cyclosporine (ciclosporin)			
Anti-proliferative: □ Mycophenolic acid (mycophenolate sodium or mycophenolate mofetil) □ Azathioprine			
mTOR: □ Everolimus □ Sirolimus			
Corticoteroids: □ Prednisone □ Prednisolone			

*Any of the following immunosuppression combinations:
1. Calcineurin inhibitors (CNI) + Anti-Proliferative +/- Corticosteroid; OR
2. CNI + mTOR inhibitor +/- Corticosteroid; OR
3. mTOR inhibitors + Anti-Proliferative +/- Corticosteroid.

Drug Prophylaxis	
Description	Date dispensed (mm/dd/yyyy)
☐ Nystatin	
☐ Valacyclovir OR ☐ Valganciclovir	
☐ Isoniazid (INH)	
☐ Cotrimoxazole	

Drug Level Monitoring*	
Description	Date (mm/dd/yyyy)
☐ Tacrolimus (trough)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____
☐ Cyclosporine (trough or C2)	
☐ Sirolimus (trough)	
☐ Everolimus (trough)	

*The following rules shall apply:

1. Maximum availment of 10x ; Applicable to kidney recipients during the first year after the kidney transplant procedure;
2. Maximum availment of 4x a year; Applicable to kidney recipients starting from the 13th month after the kidney transplant procedure

Laboratory Tests*						
Description	Date (mm/dd/yyyy)					
As prescribed:						
☐ Complete blood count (CBC)						
☐ Creatinine						
☐ Sodium (Na)						
☐ Potassium (K)						
☐ Fasting blood sugar (FBS)						
☐ Serum glutamic pyruvic transaminase (SGPT)						
☐ Urinalysis						
☐ Urine total protein creatinine ratio (UTPCR) or Urine albumin creatinine ratio (UACR)						

Laboratory Tests*						
Description	Date (mm/dd/yyyy)					
Lipid profile: □ Total cholesterol □ High-density lipoprotein (HDL) cholesterol □ Low-density lipoprotein (LDL) cholesterol □ Triglycerides						
As indicated:						
□ Albumin						
□ Prothrombin time (PT)						
□ Partial thromboplastin time (PTT)						
□ HbA1c						
*Laboratory tests can be prescribed multiple times, subject to the amount limit per claim						

Procedure	
Description	Date (mm/dd/yyyy)
□ Renal graft biopsy (Once a year, if indicated)	

Diagnostic Tests	
Description	Date (mm/dd/yyyy)
□ Chest X-ray*	
□ Whole abdominal ultrasound*	
□ Renal graft doppler (as indicated)*	
*Once a year	

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

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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 Essential Health Services -Living Kidney Donor

Place a (✔) in the appropriate tick box if the service is done or given.

Essential Health Services	
Mandatory Services	**As needed / As indicated**
□ Creatinine Date(mm/dd/yyyy) 1. _____ 2. _____ 3. _____ 4. _____	□ Fasting blood sugar (FBS) Date(mm/dd/yyyy) 1. _____ 2. _____
□ Urinalysis Date(mm/dd/yyyy) 1. _____ 2. _____ 3. _____ 4. _____	□ Random urine total protein:creatinine ratio or □ random urine albumin:creatinine ratio Date(mm/dd/yyyy) 1. _____ 2. _____

MASTER COPY Date: 6/19/25

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

SOCOTEC ISO 9001

PAB PAB ACCREDITED QMS CERTIFICATION BODY

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(02) 8662-2588 www.philhealth.gov.ph
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Case No. _____

HEALTH FACILITY (HF)		
ADDRESS OF HF		AGE: _____
A. PATIENT	1. Last Name, First Name, Suffix, Middle Name	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 ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐	

Post Kidney Transplant Passport

A. Immunosuppressive medicines

Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							

Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.							
32.							
33.							
34.							
35.							
36.							
37.							
38.							
39.							
40.							

B. Drug Prophylaxis

Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

Name of Drug		Dosage	Preparation	Date Dispensed (mm/dd/yyyy)	Quantity	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
Generic Name	Brand Name						
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							

C. Drug Level Monitoring

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

D. Laboratory Tests

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
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34.			
35.			
36.			
37.			
38.			
39.			
40.			

E. Renal Graft Biopsy

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature

F. Diagnostic Tests

Description	Date Given (mm/dd/yyyy)	Patient/ Parent/ Guardian's Signature	Attending Physician's signature
1.			
2.			
3.			

Annex G: Letter of Intent for Transfer of Care to a Referral Contracted Health Facility

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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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Letter of Intent for Transfer of Care to a Referral Contracted HF

This is to certify, that patient _____, born on _____,
(Name of the Patient) (Date of Birth)

age_____ years old, residing at _____,
(Address)

was diagnosed with _____ on _____
(Diagnosis) (Date: mm/dd/yyyy)

at the _____
(Name of the Referring Contracted HF)

We would like request for transfer of post-kidney transplantation services to _____

_____
(Name of Referral Contracted HF)

under the care of _____.
(Name of the Attending Physician)

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Date:

cc:

We understand that upon transfer to a referral contracted HF, we will have to waive all subsequent claims as the referring contracted HF.

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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 ☐☐-☐☐☐☐☐☐☐☐-☐	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Physician, Referring Contracted HF
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date signed (mm/dd/yyyy)

Certified correct by:	Certified correct by:
(Printed name and signature) Z Benefits Coordinator, Referring Contracted HF	(Printed name and signature) Billing Clerk, Referring Contracted HF
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Acknowledged by:	Acknowledged by:
(Printed name and signature) BAS Head or Authorized Signatory, PhilHealth Regional Office _____ In-charge of the Referring Contracted HF (To provide a copy to the referring Contracted HF five working days upon receipt of the form; scanned copy is allowed)	(Printed name and signature) Head or Z Benefits Coordinator, Referral Contracted HF
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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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 ☐☐ - ☐☐☐☐☐☐☐☐ - ☐	

CHECKLIST FOR PATIENT TRANSFER TO A CONTRACTED HF
Z Benefits Package for Post-Kidney Transplantation Services

NAME OF REFERRAL CONTRACTED HF:
ADDRESS OF REFERRAL CONTRACTED HF:

Requirements	YES OR NO (tick appropriate box)	Signature of Responsible Person
1. Updated Medical Abstract	☐ Yes ☐ No	
2. Letter of Referral from Attending Physician	☐ Yes ☐ No	_____ Name and Signature Attending Physician
3. Certified true copy of the post-kt passport	☐ Yes ☐ No	_____ Name and Signature Z Benefits Coordinator
4. Letter of Intent from patient requesting for transfer to a referral contracted HF (Annex G)	☐ Yes ☐ No	_____ Name and Signature Patient/Parent/Guardian

Certified complete by:	Conforme by:
_____ Printed name and signature Z Benefits Coordinator	_____ Printed name and signature Patient/Parent/Guardian
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

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Annex I.1: Checklist of Requirements for Reimbursement - Kidney Transplant Recipient - Adult

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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 Requirements for Reimbursement
Kidney Transplant Recipient - Adult

(Place a ✔ if attached or NA if not applicable)

REQUIREMENTS	Status
1. Transmittal Form (Annex J)	
2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
3. Properly Accomplished PhilHealth Claim Form 2 (CF2)	
4. Photocopy of properly accomplished Member Empowerment (ME) Form (Annex D)	
5. Completed Z Satisfaction Questionnaire (Annex K)	
6. Photocopy of the approved pre-authorization checklist and request form for Kidney Transplant Recipient - Adult (Annex A.1.)	
7. Checklist of Essential Health Services - Kidney Transplant Recipient - Adult (Annex E.1)	
8. Checklist of Requirements for Reimbursement - Kidney Transplant Recipient - Adult (Annex I.1)	
9. Post-Kidney Transplant Passport (Annex F)	
10. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent	
11. Renal biopsy result or its equivalent (For renal graft biopsy availment)	
Date Filed (mm/dd/yyyy)	

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

Annex I.2: Checklist of Requirements Reimbursement - Living Kidney Donor

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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 Requirements for Reimbursement
Living Kidney Donor

(Place a ✔ if attached or NA if not applicable)

REQUIREMENTS	Status
1. Transmittal Form (Annex J)	
2. Properly Accomplished PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF)	
3. Properly Accomplished PhilHealth Claim Form 2 (CF2)	
4. Photocopy of the approved pre-authorization checklist and request form for Living Kidney Donor (Annex A.2.)	
5. Checklist of Essential Health Services - Living Kidney Donor (Annex E.2)	
6. Checklist of Requirements for Reimbursement - Living Kidney Donor (Annex I.2)	
7. Original or Certified True Copy (CTC) of the Statement of Account (SOA) or its equivalent	
Date Completed (mm/dd/yyyy)	
Date Filed (mm/dd/yyyy)	

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

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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: Z027A
4. For the Case Number, copy the case number that is provided in the approved pre-authorization checklist and request, if applicable.
5. The Remarks column may include some relevant notes which pertain to the filed claim that need to be relayed to PhilHealth.

	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.						
8.						

MASTER COPY Date: 6/19/25 DC:

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)		

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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
   - □ Orthopedic implants
   - □ Peritoneal dialysis
   - □ Colorectal cancer
   - □ Post kidney transplantation services
   - □ Prevention of preterm delivery
   - □ Preterm and small baby
   - □ Children with developmental disability
   - □ Children with mobility impairment
   - □ Children with visual disability
   - □ Children with hearing impairment
   - □ Surgery for ventricular septal defect
   - □ ZMORPH/Expanded ZMORPH
   - □ Heart Valve Surgery

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: _____