

Pre-Certification Form



Must Be Completed and requires 48 hours to process

Retroactive Request requires 15 days to process

Failure to complete this form in its entirety may result in the delay of review

Print Name		ID/Policy#	Group#	Date of Birth
Admitting/Ordering Physician Name	Check one: <u>Network</u> IN <input type="checkbox"/> OUT <input type="checkbox"/>	Phone#	Fax#	Contact
NPI:				Ext:
Facility Providing Services:	Check one: <u>Network</u> IN <input type="checkbox"/> OUT <input type="checkbox"/>	Phone#	Fax#	Contact
Tax ID:				Ext:
Diagnosis Codes	Diagnosis			
CPT or Supply Codes	Procedure/Surgery/DME/Admission: services you are providing			
Date of Admission or Start Date of Service			Date of Discharge or End Date of Service	
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient/ 24-hour observation				
Document Supporting Clinical Below or Include Clinical Office Notes to Support Your Request				
Total number of pages faxed: 				
For Reviewer Use Only:				
Receipt Date: _____		Decision Date: _____		Notification Date: _____
Notified By: _____		Criteria _____		Signature: _____
Retro Penalty: Y N		Reviewer Approval Status: Y N		
AUTHORIZATION#:		VALID DATE(S):		

- ◆ THIS AUTHORIZATION DOES NOT GUARANTEE PAYMENT
- ◆ PAYMENT IS SUBJECT TO MEMBER ELIGIBILITY, NETWORK AND COVERAGE AT THE TIME OF SERVICE
- ◆ IF YOU WISH TO APPEAL THIS DECISION, CHANGE THE DATE OF SURGERY, OR CHANGE THE PLANNED SURGICAL PROCEDURE PLEASE CONTACT US AT THE PHONE NUMBER BELOW
- ◆ **IF YOU DO NOT RECEIVE RESPONSE WITHIN 2 BUSINESS DAYS, CONTACT US AT THE NUMBER BELOW**
- ◆ **CONFIDENTIALITY NOTICE:**

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Toll Free Tel. 1-800-485-0941

Toll Free Fax 1-800-783-6182