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 **NPI:**	**Check one:** **Network** **IN** ☐ **OUT** ☐	**Phone#**	**Fax#**	**Contact** **Ext:**
Facility Providing Services: **Tax ID:**	**Check one:** **Network** **IN** ☐ **OUT** ☐	**Phone#**	**Fax#**	**Contact** **Ext:**
Diagnosis Codes	**Diagnosis**			
CPT or Supply Codes	**Procedure/Surgery/DME/Admission: services you are providing**			
Date of Admission or Start Date of Service **Inpatient** ☐ **Outpatient/ 24-hour observation** ☐			**Date of Discharge or End Date of Service**	
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:**