PRE-CERTIFICATION REQUEST FORM

All REQUIRE MEDICAL RECORDS TO BE ATTACHED

Phone: 888-796-0947 Fax: 866-608-9860 or 888-202-1940

Instructions:

This form is for pre-certification requests which will be processed as quickly as possible depending on the member's health condition.
Do not write STAT, ASAP, Immediate, etc. on this form. Please complete appropriate sections below.

Complete this section for expedited requests ONLY. Medicare's definition of expedited is defined as one where "applying the standard time for making a determination could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function."

If your PHYSICIAN feels the member meets the definition of expedited above, have your physician document his/her reason below:

_____

Complete remainder of form for ALL requests.

Member Information

Name:_____ Date of Birth: _____ Plan ID#:_____

Requesting Provider Information

Date of Request:_____ County: _____

Attestation required: Are you the member's PCP or an agent of the PCP? Yes ___ No ____ Signature _____

Note: Requests should be submitted through the PCP; requests not from the PCP will be reviewed with the PCP.

Requesting provider name:_____ TIN#: _____

Phone: (____)_____ Fax: (____)_____ Contact Person:_____ Ext._____

Please provide a short clinical statement to support your request (or reason for disagreement):

_____

_____

Facility Requested (No Abbreviations)	**Provider Requested** (No Abbreviations)
Name:_____	Name:_____
TIN#: _____ ☐ Non-Par	TIN#: _____ ☐ Non-Par
Phone: (_____)_____ Fax: (_____)_____	Phone: (_____)_____ Fax: (_____)_____

Diagnosis:	**ICD-10 Code(s):**
Diagnosis:	**ICD-10 Code(s):**

Service Requested: Check appropriate request(s)

- ☐ Abortions
- ☐ Acute Rehabilitation Facility
- ☐ ASC for Blepharoplasty, Podiatric Surgery, Reduction Mammoplasty, Rhinoplasty, Septoplasty, Vein treatments, Ocular Surgery, Pain Management Injections, Plastic Surgery only
- ☐ Chemotherapy
- ☐ Clinical Trials Not Approved by Medicare
- ☐ Cosmetic Procedures
- ☐ Diabetic Education
- ☐ DME > $500 (see * below)
- ☐ Enteral Feedings
- ☐ Experimental/Investigational Procedure
- ☐ Genetic Testing
- ☐ Home Health Services
- ☐ Hospice **** Notification only**
- ☐ Hyperbaric Oxygen Therapy
- ☐ Implantable pump/device or stimulator
- ☐ Injectables/Infusion Therapy
- ☐ Inpatient Hospital
- ☐ Medical Nutrition Education
- ☐ MOHS Procedure (Dermatology)
- ☐ Non-Participating Provider
- ☐ Obstetrical Care
- ☐ Orthotics/Prosthetics > than $500
- ☐ Outpatient Hospital
- ☐ Pain Management
- ☐ Radiation Therapy
- ☐ Radiology: PET, Pill or Virtual Endoscopy
- ☐ Rehab Cardiac/Pulmonary/Respiratory
- ☐ Rehab – any outpatient hospital and any office therapy > than 10 visits.
- ☐ Skilled Nursing Facility
- ☐ Sterilizations
- ☐ TMJ Joint treatment
- ☐ Transplant
- ☐ Wound Care (outpatient hospital only)

CPT or HCPC Code(s)	Description	# of Visits/Injections

*DME > $500 if purchased or > $38.50 per month if rented. Includes all wheelchairs, hospital beds, CPAPs, BiPAPs, nerve and bone growth stimulation devices and oxygen, as well as TENS devices, wound care/wound vacuums and related supplies, repairs, miscellaneous codes and all Medicare non-covered items.