

☐ ROUTINE
 ☐ URGENT
 ☐ 48 HOURS
 ☐ STAT

PLEASE SUBMIT THIS COMPLETED PRE-CERTIFICATION REQUEST WITH CLINICAL NOTES

Patient Name:		ID #:	
Date of Birth:		Patient Phone:	
SERVICE REQUESTED: ☐ Behavioral Health ☐ Chemotherapy ☐ CT Scan ☐ DME ☐ Home Health Care ☐ Infusion Therapy ☐ Inpatient ☐ Medication ☐ MRI ☐ Outpatient Surgery ☐ OT ☐ PT ☐ Skilled Nursing Facility ☐ Speech Therapy ☐ Other _____			
Date of Service:		# of Treatments Requested:	
Diagnosis and Service Codes			
ICD10 Code/ Diagnosis:		CPT Codes:	
HCPC Codes:		J codes:	
Refer-to-Provider Information – hospital/facility/provider of service			
Tax ID#:		Phone:	
Fax:		Street Address:	
City:	State:	Zip Code:	
Ordering Provider			
First Name:		Last Name:	
Tax ID#:		Phone:	
Fax:		Street Address:	
City:	State:	Zip Code:	
Contact Person			
First Name:		Last Name:	
Phone:		Fax:	
Comments:			

Approval does not guarantee that any or all benefits will be paid. The Claims Department will determine whether benefits are payable when the documentation is received. Payment of benefits will be based on Usual and Customary and is subject to all terms and requirements of the Plan. Please refer to the Summary Plan Description for details about Plan Benefits such as Limitations, Exclusions, Waivers, Pre-existing Conditions, Usual and Customary fees, etc. Routine requests will be completed within five (5) working days of receipt.