



PRECERTIFICATION DOCUMENTATION

Form Completed By: _____	Appt./Admit Date: _____
Date Form Completed: _____	Subscriber #: _____
Patient Name: _____	Birth date: _____
Address: _____	HIO/POE: _____
_____	Network: _____
Phone: _____	Primary Care Physician: _____
Requesting Physician: _____	Diagnosis: _____
Procedure/Service: _____	_____
_____	Hospital/Clinic: _____

Referral to Consultant/Vendor: _____

Address: _____

Phone: _____ Fax: _____

REQUEST

<input type="checkbox"/> Inpatient	<input type="checkbox"/> Consult ONLY	<input type="checkbox"/> Speech Therapy	Requested:
<input type="checkbox"/> Outpatient	<input type="checkbox"/> Consult & Treatment	<input type="checkbox"/> Home Health	# Visits/LOS _____
<input type="checkbox"/> Day Surgery	Tx. _____	<input type="checkbox"/> Home Infusion	<input type="checkbox"/> MH/CD Day Tx
<input type="checkbox"/> Observation Unit	<input type="checkbox"/> Medical Equipment	<input type="checkbox"/> MH/CD Office Visit	<input type="checkbox"/> SNF
<input type="checkbox"/> Office Procedure	<input type="checkbox"/> P.T./O.T.	<input type="checkbox"/> MH/CD Intensive Outpat.	<input type="checkbox"/> Other _____

History/Symptoms: _____

APPROVED

<p>Precertification is not a guarantee of payment. Coverage of preauthorized services is contingent upon eligibility and benefits at the time of service.</p> <p>If additional services are recommended, such as follow-up visits, surgical procedures, physical therapy, equipment or home health care, the services must be submitted to (Client) _____ for prior approval.</p>	<p>Date: _____</p> <p><input type="checkbox"/> If Days Available</p> <p><input type="checkbox"/> With Co-Pay</p> <p>Explanation: _____</p> <p>Signed: _____</p>	<p>Approved:</p> <p># Visits/LOS: _____</p> <p><input type="checkbox"/> If Meets Medicare Criteria</p> <p><input type="checkbox"/> No Overnight Lodging</p>
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DENIED

<input type="checkbox"/> Not a Covered Service	<input type="checkbox"/> Plan Guidelines Not Followed	<input type="checkbox"/> Does Not Meet Medical Criteria
<input type="checkbox"/> Non-Participating Provider	<input type="checkbox"/> Work-Related Injury	<input type="checkbox"/> Exceeds Benefit Level
<p align="center">As a Provider, you have the right to appeal this denial.</p>		<input type="checkbox"/> Other: _____

Explanation: _____

Signed: _____ Date: _____