Sending Notes_______ No Notes _______

PRECERTIFICATION DOCUMENTATION

Form Completed By: ______________________________
Date Form Completed: ______________________________
Patient Name: ______________________________
Address: ______________________________
____
Phone: ______________________________
Requesting Physician: ______________________________
Procedure/Service: ______________________________
____

Appt./Admit Date: ______________________________
Subscriber #: ______________________________
Birth date: ______________________________
HIO/POE: ______________________________
Network: ______________________________
Primary Care Physician: ______________________________
Diagnosis: ______________________________
____
Hospital/Clinic: ______________________________

Referral to Consultant/Vendor: ______________________________
Address: ______________________________
Phone: ______________________________ Fax: ______________________________

REQUEST

- ☐ Inpatient
- ☐ Outpatient
- ☐ Day Surgery
- ☐ Observation Unit
- ☐ Office Procedure
- ☐ Consult **ONLY**
- ☐ Consult & Treatment
- Tx. ________________
- ☐ Medical Equipment
- ☐ P.T./O.T.
- ☐ Speech Therapy
- ☐ Home Health
- ☐ Home Infusion
- ☐ MH/CD Office Visit
- ☐ MH/CD Intensive Outpat.

Requested:
Visits/LOS __________
- ☐ MH/CD Day Tx
- ☐ SNF
- ☐ Other________________

History/Symptoms: ______________________________

APPROVED

Precertification is not a guarantee of payment. Coverage of preauthorized services is contingent upon eligibility and benefits at the time of service.

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.

Date: ______________
- ☐ If Days Available
- ☐ With Co-Pay

Approved:
Visits/LOS: __________
- ☐ If Meets Medicare Criteria
- ☐ No Overnight Lodging

Explanation: ______________________________
Signed: ______________________________

DENIED

- ☐ Not a Covered Service
- ☐ Non-Participating Provider
- ☐ Plan Guidelines Not Followed
- ☐ Work-Related Injury
- ☐ Does Not Meet Medical Criteria
- ☐ Exceeds Benefit Level
- ☐ Other: ______________________

As a Provider, you have the right to appeal this denial.

Explanation: ______________________________
____
Signed: ______________________________ Date: ______________________

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