AmeriBen
Medical Management

Section 1 - Member Demographics

Date Request Submitted: _____by: ☐ Provider/Physician ☐ Facility

Patient Name: _____ DOB: _____ Gender: M / F

Address: _____

Patient ID Number: _____Patient Phone: _____

Employee Name: _____ Employer Name: _____

☐ See Attached Face Sheet for Demographics

Section 2 – Service Information

Requesting Provider: _____ Tax ID: _____NPI_____

Address: _____

Phone Number: _____ Fax Number: _____

☐In Network Provider ☐ Out of Network Provider

Please provide direct line or extension for Contact Person to facilitate call back with certification number:

Provider Contact Person: _____ Phone Number: _____

Facility Rendering Care: _____ Tax ID: _____NPI_____

Address: _____

Phone Number: _____ Fax Number: _____

Facility Contact Person: _____ Phone Number: _____

☐In Network Facility ☐ Out of Network Facility

Diagnosis Code/ICD 9 or 10(s): _____

Procedure/CPT Code(s) and number of units requesting for each code: _____

_____

Requested Date(s) of Service: _____

☐Outpatient ☐Inpatient If inpatient: ☐ER Admit ☐Direct Admit

For Behavioral Health Services: __ Mental Health __ Substance Abuse

Level of Care: __Inpatient ___Residential ___ PHP ___ IOP ___ Outpatient___In Office

If request is for PHP or IOP, please provide how many days a week patient is anticipated to attend program and specific days requested: _____

_____

_____

Is treatment mandated by a 3rd Party: ___ No ___ Yes If yes, please explain: _____

Certification is for medical necessity only and does not guarantee payment.
Please contact Customer Care 1-800-786-7930 to verify benefits, eligibility, network status and any issues with claims. The Precertification process can take up to 72 hours.
Provider will be notified of determination by call or fax, followed by a mailed notification letter.