



**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)**

Name: \_\_\_\_\_

TIN#: \_\_\_\_\_ ☐ Non-Par

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**Provider Requested (No Abbreviations)**

Name: \_\_\_\_\_

TIN#: \_\_\_\_\_ ☐ Non-Par

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**Diagnosis:**

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

**Diagnosis:**

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

**Service Requested: Check appropriate request(s)**

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

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.