

**FREEDOM**
HEALTH**OPTIMUM**
HealthCare, Inc.**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: LEE MONTGOMERY Date of Birth: 06/19/1953 Plan ID#: T9902623701

Requesting Provider Information

Date of Request: 01/15/2021 County: HILLSBOROUGH

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: Florida Orthopaedic Institute

TIN#: 59292608 ☐ Non-Par

Phone: (813) 978-9700 Fax: (855-260-7559

Provider Requested (No Abbreviations)

Name: ECHOLS

TIN#: 59292608 ☐ Non-Par

Phone: (813) 978-9700 Fax: (855) 260-7559

Diagnosis: M16.11

ICD-10 Code(s): M16.11

Diagnosis:

ICD-10 Code(s):

Service Requested: Check appropriate request(s)

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

CPT or HCPC Code(s)	Description	# of Visits/Injections
E0135	WALKER FOLDING	1
E0155	WHEEL ATTACHEMENTS	1

*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.