<Recipient Name>

{{address}} Line 1

{{address}} Line 2

{{city}}, {{stateCode}} {{zip}}

Date

|  |  |
| --- | --- |
| Patient Name: | <Member Name> |
| Reference #: | <TruCare Auth #> |
| Plan Sponsor: | <Enter Name of Group Health Plan> |
| Third Party Administrator: | <Enter name of group or remove> |
| Provider / Facility: | <TruCare System Entry> |

[Healthcare Management (HCM) is a department of Luminare Health Benefits, Inc. that conducts utilization review and is the administrator of your employer’s <choose self-funded or insured> benefit plan. <Remove this bracketed section if using the client’s letterhead.>]

The information submitted for your/your dependent’s healthcare service request is approved as meeting the definition of medically necessary under the provisions of your Plan document.

|  |  |
| --- | --- |
| **Procedure/Service Approved**: | (List(s) of specific service/s approved, e.g.: Inpatient Hospitalization; Outpatient Service, Kidney Transplant, etc. ) |
| **CPT/HCPC CODE/Description:** |  |
| **Stay Level/Place of Service:** |  |
| **Admission/Start of Service Date**: | (Service Date or To Be Determined) |
| **End of Service Date:** |  |
| (Initial /Extended/Retrospective) Approved Days: | (Delete this line if not applicable) |
| **Next Anticipated Review Date**: | (Date or To Be Determined-delete if not applicable) |
| **Total Number of Services/Days/Units Approved**: | (Insert Detail as applicable) |

This approval is valid for one (1) year from the effective date of (insert date of mailing this letter).

You, your authorized representative, or a representative of your treating facility/physician, will need to call HCM to request additional service days, if your needs exceed the above **Total Number of Services/Days/Units Approved**. This phone call is very important since the benefit plan only covers services that are approved as medically necessary.

Please remember: <Choose appropriate Language>:

🞎 Provide the anticipated discharge plan for this member.

🞎 Transfer/Transition to another level of care may require precertification. Please refer to the back of the member’s ID card for instruction.

🞎 Contact the Healthcare Management Department at 1-800-706-7427, within one business day prior to scheduling your Procedure.

🞎 A concurrent stay review is necessary if the member is not discharged on the anticipated discharge date.  Please FAX the clinical update to 717-295-1208.>

Approval of services deemed as medically necessary, is not a guarantee of benefit payment by your Plan. Reimbursement for services provided is based on the provisions outlined in your Plan document, and your employment status (if applicable) at the time that services are rendered.

Patients and providers are encouraged to verify Plan benefits through the benefit department. The telephone number is located on the Member ID card.

Should you have any questions or concerns regarding this letter, please contact the Healthcare Management Department at 1-800-706-7427, Monday through Friday.

«Image\_SIGNATURE»