Approval Template

<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> |
| 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 benefit plan. <Remove this bracketed section if using the client’s letterhead.>]

The information submitted for your/your dependent’s healthcare service request met 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 or HCPC CODE/Description** |  |
| **Stay Level** |  |
| **Admission/Start of Service Date**: | (Service Date or To Be Determined) |
| **End 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 of medical necessity is valid for one (1) year from the effective date of (insert date of this letter is mailed).

You (or 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 **Total Number of Services/Days/Units Approved** above.

This medical necessity approval does not guarantee benefit coverage by your Plan. Patients and providers are encouraged to verify Plan benefits through the benefit department. The telephone number is located on the Member ID card.

**It is important for you to remember:**

* 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 1-800-480-6658, within one business day prior to scheduling any 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.

Should you have any questions or concerns regarding this letter, please contact the Healthcare Management Department at 1-800-480-6658, Monday through Friday.