**UTILIZATION MANAGEMENT**

**TEL # : 800-777-9428**

**FAX: 949-809-8931**

**ROUTINE  URGENT  48 HOURS  STAT**

**PLEASE SUBMIT THIS COMPLETED PRE-CERTIFICATION REQUEST WITH CLINICAL NOTES**

|  |  |
| --- | --- |
| Patient Name: | ID #: |
| Date of Birth: | Patient Tel #: |

**SERVICE REQUESTED:**

Inpatient  Outpatient Surgery  Medication  DME  PT  OT  Speech Therapy  Home Health Care  Infusion Therapy  Chemotherapy  Skilled Nursing Facility  MRI  CT Scan  Behavioral Health  Other  **\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF SERVICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # OF TREATMENTS REQUESTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIAGNOSIS AND SERVICE CODES**:

|  |  |
| --- | --- |
| ICD10 Code/ Diagnosis: | CPT Codes: |
| HCPC Codes: | J Codes: |

**REFER- TO- PROVIDER INFORMATION - HOSPITAL/FACILITY/ PROVIDER OF SERVICE:**

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Tax ID#: | Tel #: |
| Fax #: | Address: |
| Address, cont.: | |

**ORDERING PROVIDER**:

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Tax ID#: | Tel #: |
| Fax #: | Address: |
| Address, cont.: | |

**CONTACT PERSON**:

|  |  |
| --- | --- |
| First Name: | Last Name: |
| Tel #: | Fax #: |
| Comments: | |

**Approval does not guarantee that any or all benefits will be paid. The Claims Department will determine whether benefits are payable when the documentation is received. Payment of benefits will be based on Usual and Customary and is subject to all terms and requirements of the Plan. Please refer to the Summary Plan Description for details about Plan Benefits such as Limitations, Exclusions, Waivers, Pre-existing Conditions, Usual and Customary fees, etc.. Routine requests will be completed within 5 working day of receipt.**