**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.**