

DOCTORS DIRECT HEALTHCARE

**Pre-Certification Form - Must Be Complete and
requires 48 hours to process**

Retroactive Request requires 15 days to process

Patient Name (required)		ID / Policy# (required)	Group # (required)	Date of Birth (required)
Admitting/Ordering Physician Name	Check one: Network IN <input type="checkbox"/> OUT <input type="checkbox"/>	Phone #	Fax #	Contact Ext:
Where Are You Sending the Patient for Services?	Check one: Network IN <input type="checkbox"/> OUT <input type="checkbox"/>	Phone #	Fax #	Contact Ext:
Diagnosis Codes	Diagnosis			
CPT or Supply Codes	Procedure/Surgery/DME/Admission: services that you are providing			
Date of Admission or Start Date of Service <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient / 24 hour observation		Date of Discharge or End Date of Service		
Document Supporting Clinical Below or Include Clinical Office Notes to Support Your Request Total number of pages faxed: <input type="text"/>				
For Doctors Direct Healthcare Use Only: Date Rec'd _____ Criteria _____ DDHC Approved: Y N DATE: _____ Date Letter/Fax Sent: _____ Representative Signature: _____				

NOTE:

- ◆ THIS AUTHORIZATION DOES NOT GUARANTEE PAYMENT.
- ◆ PAYMENT IS SUBJECT TO MEMBER ELIGIBILITY, NETWORK AND COVERAGE AT THE TIME OF SERVICE.
- ◆ IF YOU WISH TO APPEAL THIS DECISION, CHANGE THE DATE OF SURGERY, OR CHANGE THE PLANNED SURGICAL PROCEDURE PLEASE CONTACT US AT THE PHONE NUMBER BELOW.
- ◆ IF YOU DO NOT RECEIVE RESPONSE WITHIN 2 BUSINESS DAYS PLEASE CONTACT US AT THE NUMBER BELOW

CONFIDENTIALITY NOTICE:

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