Pre-Certification Form

Must Be Completed and requires 48 hours to process
Retroactive Request requires 15 days to process

Failure to complete this form in its entirety may result in the delay of review

<table>
<tr><td colspan="2">Print Name</td><td>ID/Policy#</td><td>Group#</td><td>Date of Birth</td></tr>
<tr><td>Admitting/Ordering Physician Name

Tax ID:</td><td>Check one:
<u>Network</u>
IN ☐
OUT ☐</td><td>Phone#</td><td>Fax#</td><td>Contact

Ext:</td></tr>
<tr><td>Where Are You Sending the Patient for Services?</td><td>Check one:
<u>Network</u>
IN ☐
OUT ☐</td><td>Phone#</td><td>Fax#</td><td>Contact

Ext:</td></tr>
<tr><td>Diagnosis Codes</td><td colspan="4">Diagnosis</td></tr>
<tr><td>CPT or Supply Codes</td><td colspan="4">Procedure/Surgery/DME/Admission: services that you are providing</td></tr>
<tr><td colspan="3">Date of Admission or
Start Date of Service

☐ Inpatient ☐ Outpatient/ 24 hour observation</td><td colspan="2">Date of Discharge or
End Date of Service</td></tr>
<tr><td colspan="5">Document Supporting Clinical Below or Include Clinical Office Notes to Support Your Request

Total number of pages faxed: ☐</td></tr>
<tr><td colspan="5">For Reviewer Use Only:
Receipt Date: ____________ Reviewer Approved: Y N Decision Date: ____________ Notification Date: _________

Notified By: ____________ Criteria____ Signature: _________________

Retro Penalty: Y N</td></tr>
<tr><td colspan="3">AUTHORIZATION#:</td><td colspan="2">VALID DATE(S):</td></tr>
</table>

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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Tel. (229) 249-0940 or Toll Free 1-877-949-0940

Fax (229) 249-9840