PRECERTIFICATION FORM

Fax to: (316) 928-2539

PROVIDER TO COMPLETE ALL SECTIONS BELOW

Member Name:	Date of Birth:
Insurance ID Number:	Phone Number:

☐ Elective for routine, non-urgent services

☐ Expedited/Urgent-Urgent: Needed urgently, if not, could seriously jeopardize the life/health or ability of member to regain maximum function or, in your opinion, would subject member to severe pain that cannot be adequately managed without the service/treatment requested below.

Clinical Necessity for Urgent/Expedited request: _____

REQUESTING / ORDERING PROVIDER

Ordering Provider Name:	
Address:	
Return to Name:	
Return Fax:	Telephone:
Attach imaging studies, progress notes, results of conservative treatment and any other clinical documentation that support the medical necessity for testing, treatment, or admission. Failure to include records or complete this form in its entirety will only delay the processing of your request.	

PLACE OF SERVICE

Proposed Facility Name:
Address:
Tax ID:
NPI:
Is this facility a hospital, owned by or share a Tax ID with a hospital? Y N **If the facility is a hospital or shares a Tax ID with a hospital, a hospital-based facility copay of up to $500 per image for imaging services and $1,000 for outpatient surgery will apply. Copay will ONLY be waived when a free-standing, non-hospital owned facility is utilized.**

INPATIENT SERVICES

***** ACTUAL RECORDS MUST BE SUBMITTED FOR REVIEW. SENDING THE MEDICAL NECESSITY REVIEW PERFORMED BY UR/CM IS NOT SUFFICIENT SUPPORTING DOCUMENTATION. *****

Anticipated Admission Date_____ OP to IP Status? Y N

Days Requested_____ **Discharge date if applicable** _____

Type of Request:

☐ Initial ☐ Reconsideration ☐ Resubmission

☐ Length of Stay Extension: ☐ Additional Days Requested

Place of Service:

☐ Acute Care ☐ Rehab ☐ SNF ☐ LTAC

☐ Psych Full IP/Partial IP/Residential ☐ Res Sub Abuse

ICD-10 code _____ _____ _____ _____ _____

CPT x units _____ _____ _____ _____ _____

OUTPATIENT SERVICES

Anticipated Date of Service_____

Type of request:

☐ Initial ☐ Reconsideration ☐ Resubmission

☐ Surgery:

Will Robotic Assist be used? ◯ Yes ◉ No (not covered by the plan)

☐ Infusion

☐ Chemotherapy/Radiation

☐ Imaging/Advanced Radiology: *CT, MRI/MRA, PET, Nuclear, Echo*

☐ DME: Bone Growth Stimulator, Electric Scooter, Pneumatic Compression Sleeve, Spinal Cord Stimulator

☐ Wound Care

ICD-10 code _____ _____ _____ _____ _____

CPT x units _____ _____ _____ _____ _____

*****Implant Device-Benefit max of 100% of manufacturer invoice or scheduled benefit pricing, whichever is greater*****

*****Facility charges for preventive colonoscopy will be limited to a maximum allowance of $5,000 per procedure*****

*****This is not a determination of benefits, please contact the health plan benefits administrator to verify eligibility and benefits*****

*****By submitting this form, the provider is hereby agreeing to receive a written notice delivered via facsimile*****