



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

PLACE OF SERVICE

Ordering Provider Name:		Proposed Facility Name:
Address:		Address:
Return to Name:		Tax ID:
Return Fax:	Telephone:	NPI:
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.		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

OUTPATIENT SERVICES

<p>*** ACTUAL RECORDS MUST BE SUBMITTED FOR REVIEW. SENDING THE MEDICAL NECESSITY REVIEW PERFORMED BY UR/CM IS NOT SUFFICIENT SUPPORTING DOCUMENTATION. ***</p> <p>Anticipated Admission Date _____ OP to IP Status? Y N</p> <p>Days Requested _____ Discharge date if applicable _____</p> <p>Type of Request: ____ Initial ____ Reconsideration ____ Resubmission ____ Length of Stay Extension: ____ Additional Days Requested</p> <p>Place of Service: ____ Acute Care ____ Rehab ____ SNF ____ LTAC ____ Psych Full IP/Partial IP/Residential ____ Res Sub Abuse</p> <p>ICD-10 code _____</p> <p>CPT x units _____</p>	<p>Anticipated Date of Service _____</p> <p>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</p> <p>ICD-10 code _____</p> <p>CPT x units _____</p>
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*****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*****

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