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**
Anticipated Admission Date__________________ OP to IP Status? Y N Days Requested_________ Type of request: _____Initial _____Reconsideration _____Resubmission _____Length of Stay Extension:_____Additional Days Requested _____OB _____Psych _____Medical _____Surgical _____Burn _____CCU _____ICU _____PICU _____NICU _____General _____Residential Treatment ICD-10 code ________ ________ ________ ________ ________ CPT x units ________ ________ ________ ________ ________	Anticipated Date of Service_______________ Type of request: ____Initial _____Reconsideration _____Resubmission _____Surgery _____Infusion _____Chemotherapy/Radiation _____Imaging/Advanced Radiology: CT MRI/MRA PET Nuclear Echo _____DME: Bone Growth Stimulator, Insulin Pump, Electric Scooter, Pneumatic Compression Sleeve, Spinal Cord Stimulator _____Wound Care ICD-10 code ________ ________ ________ ________ ________ CPT x units ________ ________ ________ ________ ________

*****Implant Device-Benefit max of 200% of manufacturer invoice or scheduled benefit pricing, whichever is greater*****

*****Facility charges for preventive colonoscopy will be limited to a maximum allowance of $3,000 per procedure*****

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

The information contained in this communication is privileged and confidential information intended only for the use of the individual or entity named. Unauthorized review, use, or disclosure may be a violation of federal, state, and/or local law. The authorized recipient is prohibited from disclosing the information to any other party without the sender's consent. If the reader of this communication is not the intended recipient, please be advised that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately.

Care Advocates/ 345 N. Riverview / Suite 750 / Wichita, KS 67203
Tel: (316) 616-6181 / Toll Free: (844) 643-5104 / Fax: (316) 928-2539
www.careadvo.net