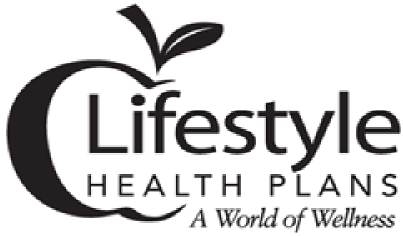
OUT-PATIENT PRECERTIFICATION FORM

Fax to: (316) 616-6161



Medical Necessity: Approved/Denied	Proposed Facility: Approved/Denied
Authorization Number:	Date Issued:
Notes	

For Lifestyle Care Coordination Use Only

Member Name	Member ID
Date of Birth	Phone No.

ICD-10 CODE(S)	

CPT CODE(S) x units	

Attach clincal records, medical history, supporting lab/imaging reports, etc., if necessary

Prospposed Facility:		
Is this facility owned, partially or in-full, by a hospital, health system or similar organization?	Yes	No
Tax ID:	Date of Service:	

Hospital-based facilities are not approved, at full benefit coverage, for out-patient services. If requesting service at a hospital-based facility, please provide justification in the space below. Services performed without approval will incur an additional copay: $1,000 for surgery; $500 for imaging

Return to:	Dept/Office:
Fax:	Phone:
Ordering Provider:	Organization:
Address:	
Fax:	Phone:

This authorization is valid for 30 days from the date of issue, and only applies if the patient is eligible for medical benefits at the time services are rendered. This authorization is not a guarantee of benefits and is subject to all plan provisions and limitations .

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A Product of Medova Healthcare / 345 N. Riverview / Suite 600 / Wichita, KS 67203
Tel: (316) 616-6160 / Toll Free: (844) 643-5104 / Fax: (316) 616-6161
www.lifestylehealthbenefits.com