PRE-CERTIFICATION / AUTHORIZATION FORM

Fax to: 954-767-5649
Today's Date: ______________

Request Priority (circle one): Stat Urgent Routine
LOB (circle one): PPUC PSN CMS Other

Member Information:

Member Name: ________________________ DOB: ________
Member SS #: ________________ Member ID #: ________________
Member Address: ________________________
Member Phone #: ______________

Physician/Provider Information:

Office Contact Name: ________________________ Phone #: ____________
Services requested by (check one): PCP ___ Specialist ___
PCP Name: ________________ PCP Phone #: ________ PCP fax #: ________
Specialist: ________________ Phone #: ________ Fax #: ________
Specialty: ____________ Address: ________________________
Requesting Physician Signature: ________________ Date: ____________

Clinical Information:

Diagnosis (ICD-9): ________________________________
Clinical Summary/findings: ________________________________
____
(Please attach relevant office records, test results, attempted treatment, second opinion and consults)

Requested Services: Type of service (Circle one): Inpatient Outpatient Office

Consultation only: ____ Follow-up: _____ Number of visits requested (circle): 1 2
Requested Services (Please provide CPT codes): ________________________________
____
Name of Facility: ____________ Estimate Length of Stay: ________

For Best Choice Plus Internal Use Only

Approved Date: ________ Authorization #: ________________ (Use within 60 days)
Pended: Date: ________ Reason: ________________________
Denied: Date: ________ Reason: ________________________

Statement to provider: This authorization is for medically necessary services only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits and patient eligibility at the time of service. Additionally, it is important that a report of the treatment provided or service(s) recommended be completed on this member and forwarded to the primary care physician.

*******NOTICE *******

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