healthteam advantage

2017

PHONE: 855-359-9999 FAX: 888-965-1964

❑ Pre-Certification ❑ Referral/Notification

Submitted by:(select one) ❑ PCP Office ❑ Specialist Office		Today's Date: / /
Person to contact for this Submission:		
Phone:	FAX:	

Patient's Name:	DOB / /	Member ID:
Patient PCP:	NPI:	

Proposed Date of Service: / /				
Treating Provider:			NPI:	
Other Provider Name: (i.e. Facility)			NPI:	
Phone:			FAX:	
❑ Outpatient	❑ Office	❑ Inpatient		❑ Ambulatory Surgery Center

ICD-10 CM Diagnosis Description	ICD-10 CM Code
Procedure: CPT/HCPCS Exact Description	CPT/HCPC Code
Describe any **special circumstances** which should be considered when authorizing services:	
Clinical Information: (You may attach additional clinical)	

This request will be treated as per the standard organization determination timeframes. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

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_____

_____

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.