



OUTPATIENT SERVICES PRECERTIFICATION OF CARE FORM

ALL REQUESTED INFORMATION MUST BE PROVIDED. INCOMPLETE FORMS WILL NOT BE REVIEWED AND WILL BE RETURNED TO SENDER. MEDICAL RECORDS ARE REQUIRED FOR REVIEW.

IF YOU HAVE ANY QUESTIONS OR IF THIS IS AN **URGENT REQUEST** PLEASE CALL (855)230-6960.

PLEASE RETURN THIS COMPLETED FORM TO:

SECURE FAX
(859) 253-0099

PATIENT INFORMATION				
MEMBER NAME ON ID CARD		MEMBER NUMBER		GROUP NUMBER
PATIENT NAME		PATIENT DATE OF BIRTH	GENDER	PATIENT PHONE NUMBER
PATIENT ADDRESS			RELATIONSHIP TO MEMBER	
IS THERE OTHER HEALTH COVERAGE		OTHER CARRIER NAME		
YES <input type="checkbox"/> NO <input type="checkbox"/>				
MEMBER NUMBER			DID OTHER CARRIER AUTHORIZE	
			YES <input type="checkbox"/> NO <input type="checkbox"/>	
REQUESTING PROVIDER INFORMATION				
PROVIDER NAME		PROVIDER ADDRESS		
TAX ID NUMBER	NPI NUMBER	TELEPHONE	FAX	
SERVICING PROVIDER INFORMATION				
PROVIDER NAME		PROVIDER ADDRESS		
TAX ID NUMBER	NPI NUMBER	TELEPHONE	FAX	

SERVICING FACILITY INFORMATION			
FACILITY NAME		FACILITY ADDRESS	
TAX ID NUMBER	NPI NUMBER	TELEPHONE	FAX
PROCEDURE INFORMATION			
DATE OF PROCEDURE	CPT CODE	PROCEDURE DESCRIPTION	
____-____-____			
UNITS	FREQUENCY		
DATE OF PROCEDURE	CPT CODE	PROCEDURE DESCRIPTION	
____-____-____			
UNITS	FREQUENCY		
ADDITIONAL INFORMATION			
CLINICAL INFORMATION			
DIAGNOSIS CODE ICD10 REQUIRED	DESCRIPTION		
DIAGNOSIS CODE ICD10 REQUIRED	DESCRIPTION		
DIAGNOSIS CODE ICD10 REQUIRED	DESCRIPTION		
IS THIS INJURY RELATED	DATE OF INJURY	TYPE OF INJURY	
YES <input type="checkbox"/> NO <input type="checkbox"/>	____-____-____		
PROVIDE PERTINENT ADDITIONAL INFORMATION INCLUDING RELEVANT TESTING			
SUBMITTED BY	PHONE	FAX	DATE OF SUBMISSION
			____-____-____

REQUESTING PROVIDER SIGNATURE: _____

DATE: ____-____-____