CARE ADVOCATES

Precertification Form

Fax to: (316) 928-2539

PROVIDER TO COMPLETE ALL SECTIONS BELOW

CAHW HEALTH & WELLNESS

MEMBER INFORMATION

Member Name:	Birth Date:
Insurance ID Number:	Phone Number:

☐ Elective for routine, non-urgent services

☐ Expedited / 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 service / treatment requested below.

Clinical Neccessity for Urgent / Expedited request: ______________________________

REQUESTING / ORDERING PROVIDER

Ordering Provider Name:			
Street Address:	City:	State:	Zip Code:
Return to Name:	Return Fax:	Telephone:	

NOTE: 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.

PLACE OF SERVICE

Proposed Facility Name:	NPI:		
Street Address:	City:	State:	Zip Code:
Tax ID:	Is this Facility a hospital, owned by or share a Tax ID with a hospital? ☐ Yes ☐ No		
Is it medically necessary for the procedure to be performed in a hospital? ☐ Yes ☐ No If "Yes", please attach medical records documenting such need			

NOTE: If the facility is a hospital or shares a Tax ID with a hospital, a hospital-based facility copay (which is often as much as $500 per image or $1,000 for surgery) will apply.

INPATIENT SERVICES

** ACTUAL RECORDS MUST BE SUBMITTED FOR REVIEW. SENDING THE MEDICAL NECESSITY REVIEW PERFORMED BY UR / CM IS NOT SUFFICIENT SUPPORTING DOCUMENTATION. **

Anticipated Admission Date:	OP to IP Status? ☐ Yes ☐ No
Days Requested:	Discharge Date if applicable:

Type of Request:

☐ Initial	☐ Reconsideration	☐ Resubmission
☐ Length of Stay Extension	☐ Additional Days Requested	

Place of Service:

☐ Acute Care	☐ Rehab	☐ SNF
☐ LTAC	☐ Psych Full IP / Residential	☐ Res Sub Abuse

ICD-10 code:					
CPT x units:					

OUTPATIENT SERVICES – See www.CareAdvo.net for listing of procedures not covered at a hospital

Anticipated Date of Service:

Type of Request:

☐ Initial	☐ Reconsideration	☐ Resubmission
☐ Surgery: Will Robotic Assist be used?	☐ Yes (not covered by the plan)	☐ No
☐ Infusion	☐ DME: Bone Growth Stimulator, Electric Scooter, Pneumatic Compression Sleeve, Spinal Cord Stimulator	
☐ Imaging / Advanced Radiology: CT, MRI / MRA, PET, Nuclear, Echo		
☐ Wound Care		
☐ Dialysis	Date Dialysis began:	

ICD-10 code:					
CPT x units:					

*** Implant Device-Benefit max of 100% of manufacturer invoice or scheduled benefit pricing, whichever is greater *** Facility Charges for preventative colonoscopy will be limited to a maximum allowance of $5,000 per procedure *** Plan allowances for dialysis equal Medicare allowances *** This is not a determination of benefits, please contact the health plan benefits administrator to verify eligibility and benefits *** By submitting this form, the provider is hereby agreeing to receive a written notice delivered via facsimile ***

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