ORTHUS HEALTH

Pre-Certification Form

Must Be Complete and Requires 48 hours to process

Retroactive Request requires 15 days to process

Patient Name		Insurance ID#	Group #	Date of Birth
Admitting/Ordering MD (name) Tax ID #	Circle One: Network IN OUT	Phone #	Fax #	Contact Ext:
Facility/Provider of Service (name) Tax ID #	Check one: Network IN OUT	Phone #	Fax #	Contact Ext:
Diagnosis Codes	Diagnosis			
CPT or Supply Codes	Procedure/Surgery/DME/Admission: services that you are providing			
Date of Admission or Start Date of Service ☐ Inpatient ☐ Outpatient / 24-hour observation		Date of Discharge or End Date of Service		
Attach supporting clinical documentation to support your request. Total number of pages faxed: ☐				

For Orthus Health Use Only:

*Date Rec'd*_____ *Criteria*_____

OH Approved: Y N DATE: _____

Date Letter/Fax Sent: _____*Representative Signature:* _____

NOTE:

- ☐ THIS AUTHORIZATION DOES NOT GUARANTEE PAYMENT.
- ☐ PAYMENT IS SUBJECT TO MEMBER ELIGIBILITY, NETWORK AND COVERAGE AT THE TIME OF SERVICE.
- ☐ IF YOU WISH TO APPEAL THIS DECISION, CHANGE THE DATE OF SURGERY, OR CHANGE THE PLANNED SURGICAL PROCEDURE PLEASE CONTACT US AT THE PHONE NUMBER BELOW.
- ☐ IF YOU DO NOT RECEIVE RESPONSE WITHIN 2 BUSINESS DAYS PLEASE CONTACT US AT THE NUMBER BELOW.

Orthus Health
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CONFIDENTIAL