



# 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)	Circle One: <u>Network</u> IN OUT	Phone #	Fax #	Contact
Tax ID #				Ext:
Facility/Provider of Service (name)	Check one: <u>Network</u> IN OUT	Phone #	Fax #	Contact
Tax ID #				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		Date of Discharge or End Date of Service		
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient / 24-hour observation				
Attach supporting clinical documentation to support your request.				
Total number of pages faxed: <input type="text"/>				
<i>For Orthus Health Use Only:</i> 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.

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Orthus Health

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