



Pre-Certification Form

Complete all fields. Print form, attach all supporting clinical documentation to support your request, and fax to 1-866-252-8232

New requests - up to 2 business days to process; retroactive requests up to 15 business days

Submission Date: ____/____/____

Total number of pages faxed (including cover page) _____

Patient Information:

Name: _____

Insurance Provider: _____

Date of Birth: ____/____/____

Employer Name: _____

Admitting/Ordering MD

Name: _____

Contact Name: _____

Tax ID/NPI: _____

Contact Phone Number: _____

In Network Out of Network

Contact Fax Number: _____

Facility/Provider of Service

Name: _____

Contact Name: _____

Tax ID/NPI: _____

Contact Phone Number: _____

In Network Out of Network

Contact Fax Number: _____

Diagnosis Codes: _____

CPT or Supply Codes: _____

Diagnosis: _____

Procedure / Surgery / DME / Admission / Services being provided: _____

Date of Admission OR Start Date of Service

Date of Discharge OR End Date of Service

____/____/____

____/____/____

Inpatient Outpatient / 24-hour observation

For Orthus Health Use Only

Date Received: ____/____/____ Criteria: _____

Orthus Health Approved: Yes No Date Approved: ____/____/____

Date Response Sent: ____/____/____ Orthus Health Representative Signature: _____

NOTE:

- Payment is subject to member eligibility, network, and coverage at time of service. Authorization does not guarantee payment
- To appeal this decision, change surgery date, or change planned surgical procedure, call 1-800-550-2427
- **IF YOU DO NOT RECEIVE A RESPONSE WITHIN 2 BUSINESS DAYS, CALL 1-800-550-2427**

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