



PRE-CERTIFICATION PROCESS

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Freedom Health Pre-Certification Request Form

Phone: (888) 796-0947 Fax: (866) 866-9242 or (813) 506-6231

Do not make an appointment until authorization has been received. ***If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.***

Please see list for Pre-certification Requirements

Date: <input type="checkbox"/> Standard (7-14 days) <input type="checkbox"/> Urgent (3-5 days)		PCP/Ordering MD Name:		Requested by <input type="checkbox"/> Member <input type="checkbox"/> Provider	
Member Name:		Phone #:			
Member ID:		Fax#:			
Dx ICD9 Code(s):		TIN#:			
Dx: Description:		Office Contact Person:		Ext:	
Facility Requested (No Abbreviations) Name:			Physician/Provider/Agency Requested (No Abbreviations) Name:		
TIN#: <input type="checkbox"/> Non-Par			TIN#: <input type="checkbox"/> Non-Par		
Phone#:			Phone#:		
Fax#:			Fax #:		
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Ctr. Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services <u>Must be homebound for Medicare to cover</u> Date(s) of Service: _____ <input type="checkbox"/> SN # of visits: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits _____ Reason and codes for visit: _____ _____					
Outpatient Rehab Date(s) of Service: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____ Reason and codes for rehab: _____ _____					
DME /Genetic testing/Special Laboratory/Miscellaneous					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital or outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services



Freedom Health Pre-Certification Request Form

Phone: (888) 796-0947 Fax: (888) 736-1123 or (813) 506-6226

Do not make an appointment until authorization has been received. ***If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.***

Please see list for Pre-Certification Requirements

Date: <input type="checkbox"/> Standard (7-14 days) Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days)		PCP/Ordering MD Name:		Requested by <input type="checkbox"/> Member <input type="checkbox"/> Provider	
Member Name:		Phone #:			
Member ID:		Fax#:			
Dx ICD9 Code(s):		TIN#:			
Dx: Description:		Office Contact Person:		Ext:	
Facility Requested (No Abbreviations)			Physician/Provider/Agency Requested (No Abbreviations)		
Name:			Name:		
TIN#: <input type="checkbox"/> Non-Par			TIN#: <input type="checkbox"/> Non-Par		
Phone#:			Phone#:		
Fax#:			Fax #:		
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Ctr.					
Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services <u>Must be homebound for Medicare to cover</u>					
Date(s) of Service: _____					
<input type="checkbox"/> SN # of visits: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits: _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits: _____					
Reason and codes for visit:					
Outpatient Rehab					
Date(s) of Service: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason and codes for rehab:					
DME /Genetic testing/Special Laboratory/Miscellaneous					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital or outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services



Freedom Health Pre-Certification Request Form

Phone: (888) 796-0947 Fax: (888) 202-1940 or (813) 506-6227

Do not make an appointment until authorization has been received. If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.

Please see list for Pre-certification Requirements

Date: <input type="checkbox"/> Standard (7-14 days) Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days)		PCP/Ordering MD Name: _____		Requested by <input type="checkbox"/> Member <input type="checkbox"/> Provider	
Member Name: _____		Phone #: _____			
Member ID: _____		Fax#: _____			
Dx ICD9 Code(s): _____		TIN#: _____			
Dx: Description: _____		Office Contact Person: _____		Ext: _____	
Facility Requested (No Abbreviations)			Physician/Provider/Agency Requested (No Abbreviations)		
Name: _____			Name: _____		
TIN#: _____ <input type="checkbox"/> Non-Par			TIN#: _____ <input type="checkbox"/> Non-Par		
Phone#: _____			Phone#: _____		
Fax#: _____			Fax #: _____		
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Ctr.					
Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services <u>Must be homebound for Medicare to cover</u>					
Date(s) of Service: _____					
<input type="checkbox"/> SN # of visits: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits _____					
Reason and codes for visit: _____					
Outpatient Rehab					
Date(s) of Service: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason and codes for rehab: _____					
DME /Genetic testing/Special Laboratory/Miscellaneous					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital or outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services



Freedom Health Pre-Certification Request Form

Phone: (888) 796-0947 Fax: (866) 608-9860 or (813) 506-6228

Do not make an appointment until authorization has been received. ***If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.***

Please see list for Pre-certification Requirements

Date: <input type="checkbox"/> Standard (7-14 days) <input type="checkbox"/> Urgent (3-5 days) <input type="checkbox"/> Stat(Call)		PCP/Ordering MD Name:		Requested by <input type="checkbox"/> Member <input type="checkbox"/> Provider	
Member Name:		Phone #:			
Member ID:		Fax#:			
Dx ICD9 Code(s):		TIN#:			
Dx: Description:		Office Contact Person:		Ext:	
Facility Requested (No Abbreviations) Name:			Physician/Provider/Agency Requested (No Abbreviations) Name:		
TIN#: <input type="checkbox"/> Non-Par			TIN#: <input type="checkbox"/> Non-Par		
Phone#:			Phone#:		
Fax#:			Fax #:		
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Ctr.					
Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services <u>Must be homebound for Medicare to cover</u>					
Date(s) of Service: _____					
<input type="checkbox"/> SN # of visits: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits: _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits: _____					
Reason and codes for visit:					
Outpatient Rehab					
Date(s) of Service: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason and codes for rehab:					
DME /Genetic testing/Special Laboratory/Miscellaneous					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital or outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services



Freedom Health Pre-Certification Request Form

Phone: (888) 796-0947 Fax: (866) 866-9241 or (813) 506-6230

Do not make an appointment until authorization has been received. ***If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.***

Please see list for Pre-Certification Requirements

Date: <input type="checkbox"/> Standard (7-14 days) Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days)		PCP/Ordering MD Name:		Requested by <input type="checkbox"/> Member <input type="checkbox"/> Provider	
Member Name:		Phone #:			
Member ID:		Fax#:			
Dx ICD9 Code(s):		TIN#:			
Dx: Description:		Office Contact Person:		Ext:	
Facility Requested (No Abbreviations)			Physician/Provider/Agency Requested (No Abbreviations)		
Name:			Name:		
TIN#: <input type="checkbox"/> Non-Par			TIN#: <input type="checkbox"/> Non-Par		
Phone#:			Phone#:		
Fax#:			Fax #:		
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Ctr.					
Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services <u>Must be homebound for Medicare to cover</u>					
Date(s) of Service: _____					
<input type="checkbox"/> SN # of visits: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits: _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits: _____					
Reason and codes for visit:					
Outpatient Rehab					
Date(s) of Service: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason and codes for rehab:					
DME /Genetic testing/Special Laboratory/Miscellaneous					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital or outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services

No appointments should be made for services until an authorization has been received.

Medicare allows up to 14 days to make a decision regarding a request for services. The only exception is an **expedited** request. A request can only be expedited if your physician feels that waiting up to 14 days for a decision would place the patient's life, health or ability to regain maximum function in serious jeopardy. In this case, please call the UM Department and make an expedited request for review.

All other services may be requested as Urgent or Standard. Urgent requests will be handled within 3 – 5 working days; while Standard requests will be handled within 7 -14 working days.

The following services require Pre-Certification. Please include Medical Records supporting the need for the requested services. *Without Medical Records your request cannot be processed.*

Any Inpatient or Outpatient Hospital Services	Pharmaceutical injectables/infusions – Refer to “J” code listing in your Provider Manual – Include # of injections per “J” code and duration of services (14 days, 30 days, etc.)
Any Skilled Nursing Facility Services	
Any Non-emergency transportation	New technology, investigational and experimental procedures – Must include in-depth medical records to support request.
Ambulatory Surgery Center – only Blepharoplasty, Podiatric Surgery, Reduction Mammoplasty, Rhinoplasty, Septoplasty, Vein Ligation	Non-participating Providers- Must provide medical records that support medical necessity for going out of network for these services
Cardiac or Pulmonary Rehabilitation any POS	MRA, MRI, PET , MRCP, ERCP, Biopsy, Pill Endoscopy, Virtual Colonoscopy and Nuclear Medicine except Stress Test (Nuclear Medicine excludes POS 11 and 24) please include CPT code or if no code, complete description. i.e. with or without contrast; full body or partial, etc. If ordering contrast – please have a creatinine done 12-24 hours prior to the procedure and reported to the radiology provider.
Medical Nutrition Education – Medicare coverage only for diagnosis of renal disease or diabetes.	
Clinical Trials: Not covered by the Plan, but must be reported	Cardiac Catheterization (any POS) and angiogram (any POS)
Dialysis – please include # of visits, duration of services and ESRD form if applicable	
DME items: All rental items All purchased items over \$500 per item	Outpatient PT/OT/SLT- Include # of services and duration of services (i.e., 3 weeks, 4 weeks, etc.)
Orthotics and Prosthetics – Please include codes for requested products not just description	Plastic Surgery Procedures
Genetic Testing and all Non –par Laboratories	Pain Management- Include # of services/injections and duration of services (14 days, 30 days, etc.)
Hospice Admissions – Not covered, but need to be reported. Please include Member's signed election form.	Radiation therapy/Chemotherapy- Include # of treatments or injections, duration of services (30-60-90 days,etc.)
Home Health Services- Please include: # of services per therapy and reason for services, duration of services (30 days, 60 days, etc.) and doctor's orders. Medicare members must be homebound to receive Home Health Services.	Sleep Studies
Hyperbaric Oxygen Treatments- # of treatments and duration of services (30 days, 60 days, etc.)	TMJ joint treatment, surgery, and/or splint
Implantable pumps/devices/stimulators	Wound Care Services – include # of visits, complete description of wound, etc.
	Obstetrical Care

PRE-CERTIFICATION FORM

INSTRUCTIONS



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: 888-736-1123

Do not make an appointment until authorization has been received. If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.

Please see back for more information.

Date: 1 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) <input type="checkbox"/> Standard (7-14 days) 2		PCP/Ordering MD 7		Requested by <input type="checkbox"/> Member <input type="checkbox"/> Provider 7a	
Member Name: 3		Phone #: 8			
Member ID: 4		Fax#: 9			
Dx ICD9 Code(s): 5		TIN#: 10			
Dx: Description: 6		Office Contact Person: 11		Ext: 12	
Facility Requested (No Abbreviations)			Physician/Provider/Agency Requested (No Abbreviations)		
Name: 13		Name: 17			
TIN#: 14		TIN#: 18			
Phone#: 15		Phone#: 19			
Fax#: 16		Fax #: 20			
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Center 21					
Date of Service (If already scheduled): 22					
CPT Code	Description	CPT Code	Description		
23	24				
Home Health Services Must be homebound for Medicare to cover					
Date(s) of Service: 25					
26 <input type="checkbox"/> SN # of visits: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits _____					
Reason for visits: 27					
Outpatient Rehab					
Date(s) of Service: 28					
<input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____ 29					
Reason or codes for rehab: 30					
DME Requests:					
Code	Description	Code	Description		
31	32				
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting					
CPT Code	Description	CPT Code	Description		
33	34				
Office Visits (Check One) 35 <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment 36 days					
Code	Description	# of Services	Code	Description	# of Services
37	38	39			

Instructions for Completion of Pre-Certification Form

Accuracy and completeness of the pre-certification form will:

- Decrease the time needed to finish your request
- Decrease the number of phone calls back to you for more information

Filling Out The Form

	TITLE	INSTRUCTIONS
1	Date	Enter the date you are filling out the form
2	Status	<p>This section lets us know the urgency of your request. Please do not make an appointment (if possible) until the authorization has been received. If your <u>physician</u> feels that waiting for a decision under the Medicare allowed time frame of 14 days (Standard request) would <u>place the patient's life, health or ability to regain maximum function in serious jeopardy</u> then call the UM Department at (888) 797-0947 and ask for an Expedited Review. This type of review can only be requested due to the reasons stated above.</p> <ul style="list-style-type: none"> • Stat – if an authorization is needed immediately for other reasons than stated above for “expedited” then call the UM Department at (888) 797-0947 for an authorization. If the service or need does not meet STAT requirements, then the UM staff member may ask you to fax the request in as an Urgent or Standard – which ever applies to the situation. Requests for inappropriate STATs will be tracked and trended for corrective action by the Plan. Inappropriate use of STAT slows down the process for everyone – so use it wisely. • Urgent – Answer will be given within 3-5 days • Standard – Answer will be given within 5-14 days. <p>Pre-certification forms that are complete and contain needed medical records are usually completed within 48 hours after receipt.</p>
3	Member Name	Enter member name. Please print
4	Member ID	Enter Member's Plan ID# not their Social Security Number. For Freedom this number begins with the letter “P”
5	DX ICD-9 Code	Enter all diagnosis codes that apply to the requested service
6	DX Description	Enter the description of the code entered above. EX: You entered ICD-9 Code . The description would be:
7	PCP/Ordering MD	Enter the name of the Physician requesting the service. Please enter full name, no abbreviations.
7a	Requested by Member or Provider	Please check which individual is asking for this service. A member may ask for a service that the physician does not feel is needed, but it still needs to come to the Plan to be reviewed for appropriateness of care.
8	Phone #	Enter office phone number
9	Fax#	Enter office Fax number
10	TIN#	Enter the ordering Physician's office Tax ID number
11	Office Contact Person	Enter name of person to call if any questions about this request
12	Ext	Enter the contact person's office extension number
13	Facility Requested	Enter the name of the hospital/SNF or ASC being requested if the request is for a service in this type of facility. Please do not abbreviate the name of the facility (Ex: ORMC-can be confused with Orlando Regional Medical Center or Osceola Regional Medical Center)
14	TIN#	Enter facilities Tax ID # if known
15	Phone#	Enter requested facility's phone number
16	Fax#	Enter requested facility's fax number
17	Physician/Provider/Agency Name:	Enter the name of either the Physician being requested, or the Home Health Agency, DME company or Outpatient Rehab being requested. IF OP Rehab being requested is located in a Hospital then use section 13 instead of here so the Plan knows this is a hospital-based service.
	TITLE	INSTRUCTIONS

18	TIN #	Enter Tax ID number of provider
19	Phone #	Enter phone number of provider
20	Fax #	Enter fax number of provider
21	Hospital/ASC Request	Please check if the service is going to be done as an inpatient, outpatient, Observation status or in an Ambulatory Surgery Center
22	Date of Service	Enter the date of service if the procedure has already been scheduled
23	CPT Code	Enter the CPT code of the requested procedure
24	Description	Enter the description of the CPT code being requested
Home Health Services		
25	Dates of Service	Enter the start and stop date for Home Health
26	Check the requested services	SN= Skilled Nursing; PT=Physical Therapy; OT= Occupational Therapy; MSW = Social Worker; HHA= Home Health Aide; SLT= Speech Therapy
26	Enter the number of visits being requested	If (1) one visit is requested that will be considered an evaluation only.
27	Reason for visits	Please explain why the member requires these services in the home. Medicare requires that a member be homebound to receive home health services. Explain what needs the member has i.e., wound care, etc.
Outpatient Rehab		
28	Dates of Service	Enter the begin and end dates of rehab services
29	Service and # of visits	Please select which services are needed: PT= Physical Therapy; OT= Occupational Therapy; SLT= Speech Therapy. Also enter the number of visits being requested.
30	Reason or codes for Rehab	Enter Rehab codes if known i.e.97001 for PT Evaluation. Or enter reason for therapy i.e. lumbar strain
DME /Genetic Testing/Specialized Laboratory/Miscellaneous		
31	Codes	Please enter the code for the requested DME item, Genetic test, or specialized laboratory request, or other request that does not fall into any other categories on the list
32	Code Description	Please enter the detailed description of the item code requested
Imaging Services		
33	CPT Code	Enter CPT code of the procedure being requested
34	Description	Enter description of CPT code entered; i.e.
Office Visits		
35	Type of Service	Check appropriate box if the office visits meets one of these visits. If you are asking for a non-participating provider, injections in the office, Radiation Therapy, Chemotherapy, or Pain Management.
36	Length of treatment	Please note how long the treatment will be for i.e., 4 weeks, 3 months, etc.
37	Codes	Enter codes to be performed or "J" codes that need to be authorized
38	Description	Enter description of codes entered above
39	# of Services	Enter # of services per code. If a "J" codes please enter number of injections being done per "J" code. Other codes, enter number of times it will be performed.

PRE-CERTIFICATION FORM

Example

Ambulatory Surgery Center



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: xxx-xxx-xxxx

Do not make an appointment until authorization has been received. If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.

Please see back for more information.

Date: 5/2/08 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) X Standard (7-14 days)		PCP/Ordering MD Requested by <input type="checkbox"/> Member X Provider James Smith			
Member Name: Doe, John		Phone #: (xxx)xxx-xxxx			
Member ID: Pxxxxxxx-01		Fax#: (xxx)xxx-xxxx			
Dx ICD9 Code(s): 727.1		TIN#: xxxxxxxxxxx			
Dx: Description: Bunion		Office Contact Person: Emily Ext: 2224			
Facility Requested (No Abbreviations) Name: Hibiscus Surgery Center		Physician/Provider/Agency Requested (No Abbreviations) Name: Andrew Foot			
TIN#: xxxxxxxxxxx		TIN#: xxxxxxxxxxx			
Phone#: (xxx)xxx-xxxx		Phone#: (xxx)xxx-xxxx			
Fax#: (xxx)xxx-xxxx		Fax #: (xxx)xxx-xxxx			
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations X Amb Surg Center					
Date of Service (If already scheduled): Not yet scheduled					
CPT Code	Description	CPT Code	Description		
28296	Bunion repair				
Home Health Services Must be homebound for Medicare to cover					
Date(s) of Service: _____					
<input type="checkbox"/> SN # of visits: _____ <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits _____					
Reason for visits: _____					
Outpatient Rehab					
Date(s) of Service: _____					
<input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason or codes for rehab: _____					
DME Requests:					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services

PRE-CERTIFICATION FORM

Example

Outpatient Rehab Center



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: xxx-xxx-xxxx

Do not make an appointment until authorization has been received. If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.

Please see back for more information.

Date: 5/2/08 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) X Standard (7-14 days)		PCP/Ordering MD Requested by <input type="checkbox"/> Member X Provider James Smith			
Member Name: Doe, John		Phone #: (xxx)xxx-xxxx			
Member ID: Pxxxxxxx-01		Fax#: (xxx)xxx-xxxx			
Dx ICD9 Code(s): 722.1		TIN#: xxxxxxxxxxxx			
Dx: Description: Sciatica		Office Contact Person: Emily Ext: 2224			
Facility Requested (No Abbreviations) Name:		Physician/Provider/Agency Requested (No Abbreviations) Name: Sunrise Rehab Center			
TIN#:		TIN#: xxxxxxxxxxxx			
Phone#:		Phone#: (xxx)xxx-xxxx			
Fax#:		Fax #: (xxx)xxx-xxxx			
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Center					
Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services Must be homebound for Medicare to cover					
Date(s) of Service: _____					
<input type="checkbox"/> SN # of visits: <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits: _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits: _____					
Reason for visits: _____					
Outpatient Rehab					
Date(s) of Service: _____					
X PT # of visits: 9 <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason or codes for rehab: Sudden onset of low back pain					
97110 x 9					
DME Requests:					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services

PRE-CERTIFICATION FORM

Example

Inpatient Hospital



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: xxx-xxx-xxxx

Do not make an appointment until authorization has been received. *If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.*

Please see back for more information.

Date: 5/2/08 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) X Standard (7-14 days)		PCP/Ordering MD Requested by <input type="checkbox"/> Member X Provider James Smith			
Member Name: Doe, John		Phone #: (xxx)xxx-xxxx			
Member ID: Pxxxxxxx-01		Fax#: (xxx)xxx-xxxx			
Dx ICD9 Code(s): 414.0		TIN#: xxxxxxxxxxx			
Dx: Description: Coronary Atherosclerosis		Office Contact Person: Emily Ext: 2224			
Facility Requested (No Abbreviations) Name: Tampa General Hospital		Physician/Provider/Agency Requested (No Abbreviations) Name: Thomas A. Jones			
TIN#: xxxxxxxxxxx		TIN#: xxxxxxxxxxx			
Phone#: (xxx)xxx-xxxx		Phone#: (xxx)xxx-xxxx			
Fax#: (xxx)xxx-xxxx		Fax #: (xxx)xxx-xxxx			
Hospital/ASC Requested (please check one) X Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Center					
Date of Service (if already scheduled): 06/02/08					
CPT Code	Description	CPT Code	Description		
33510	CABG				
Home Health Services Must be homebound for Medicare to cover					
Date(s) of Service:					
<input type="checkbox"/> SN # of visits: <input type="checkbox"/> PT # of visits: <input type="checkbox"/> OT# of visits: <input type="checkbox"/> MSW # of visits: <input type="checkbox"/> HHA # of visits: <input type="checkbox"/> SLT# of visits: <input type="checkbox"/>					
Reason for visits:					
Outpatient Rehab					
Date(s) of Service:					
<input type="checkbox"/> PT # of visits: <input type="checkbox"/> OT #of visits: <input type="checkbox"/> SLT # of visits: <input type="checkbox"/>					
Reason or codes for rehab:					
DME Requests:					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services

PRE-CERTIFICATION FORM

Example

Free-standing Radiology



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: xxx-xxx-xxxx

Do not make an appointment until authorization has been received. If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.

Please see back for more information.

Date: 5/2/08 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) X Standard (7-14 days)		PCP/Ordering MD Requested by <input type="checkbox"/> Member X Provider James Smith			
Member Name: Doe, John		Phone #: (xxx)xxx-xxxx			
Member ID: Pxxxxxxx-01		Fax#: (xxx)xxx-xxxx			
Dx ICD9 Code(s): 746.81		TIN#: xxxxxxxxxxx			
Dx: Description: Subaortic stenosis		Office Contact Person: Emily Ext: 2224			
Facility Requested (No Abbreviations)		Physician/Provider/Agency Requested (No Abbreviations)			
Name:		Name: Black Radiology			
TIN#:		TIN#: xxxxxxxxxxx			
Phone#:		Phone#: (xxx)xxx-xxxx			
Fax#:		Fax #: (xxx)xxx-xxxx			
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Center					
Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services <u>Must be homebound for Medicare to cover</u>					
Date(s) of Service: _____					
<input type="checkbox"/> SN # of visits: <input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT# of visits: _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits: _____					
Reason for visits: _____					
Outpatient Rehab					
Date(s) of Service: _____					
<input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason or codes for rehab: _____					
DME Requests:					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting					
CPT Code	Description	CPT Code	Description		
71555	MRA chest with and w/o contrast				
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services

PRE-CERTIFICATION FORM

Example

Home Health Services



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: xxx-xxx-xxxx

Do not make an appointment until authorization has been received. If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.

Please see back for more information.

Date: 5/2/08 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) X Standard (7-14 days)		PCP/Ordering MD Requested by <input type="checkbox"/> Member X Provider James Smith			
Member Name: Doe, John		Phone #: (xxx)xxx-xxxx			
Member ID: Pxxxxxxx-01		Fax#: (xxx)xxx-xxxx			
Dx ICD9 Code(s): 716.9		TIN#: xxxxxxxxxxxx			
Dx: Description: Arthritis		Office Contact Person: Emily	Ext: 2224		
Facility Requested (No Abbreviations) Physician/Provider/Agency Requested (No Abbreviations)					
Name:		Name: Palm Home Health Care			
TIN#:		TIN#: xxxxxxxxxxxx			
Phone#:		Phone#: (xxx)xxx-xxxx			
Fax#:		Fax #: (xxx)xxx-xxxx			
Hospital/ASC Requested (please check one) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observations <input type="checkbox"/> Amb Surg Center					
Date of Service (If already scheduled): _____					
CPT Code	Description	CPT Code	Description		
Home Health Services Must be homebound for Medicare to cover					
Date(s) of Service: _____					
X SN # of visits: 3 X PT # of visits: 9 <input type="checkbox"/> OT# of visits: _____ <input type="checkbox"/> MSW # of visits: _____ <input type="checkbox"/> HHA # of visits: _____ <input type="checkbox"/> SLT# of visits: _____					
Reason for visits: D/C from hospital after knee replacement. Nurse for wound care and PT to begin therapy.					
Outpatient Rehab					
Date(s) of Service: _____					
<input type="checkbox"/> PT # of visits: _____ <input type="checkbox"/> OT #of visits: _____ <input type="checkbox"/> SLT # of visits: _____					
Reason or codes for rehab: _____					
DME Requests:					
Code	Description	Code	Description		
Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting					
CPT Code	Description	CPT Code	Description		
Office Visits (Check One) <input type="checkbox"/> Non-Par <input type="checkbox"/> Injections <input type="checkbox"/> Rad Tx <input type="checkbox"/> Chemo <input type="checkbox"/> Pain Mgmt Length of treatment _____ days					
Code	Description	# of Services	Code	Description	# of Services

PRE-CERTIFICATION FORM

Example

Durable Medical Equipment



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: xxx-xxx-xxxx

Do not make an appointment until authorization has been received. *If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.*

Please see back for more information.

Date: 5/2/08 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) X Standard (7-14 days)	PCP/Ordering MD Requested by <input type="checkbox"/> Member X Provider James Smith
Member Name: Doe, John	Phone #: (xxx)xxx-xxxx
Member ID: Pxxxxxxx-01	Fax#: (xxx)xxx-xxxx
Dx ICD9 Code(s): 428.0	TIN#: xxxxxxxxxxx
Dx: Description: Heart Failure	Office Contact Person: Emily Ext: 2224

Facility Requested (No Abbreviations) Name:	Physician/Provider/Agency Requested (No Abbreviations) Name: Ocean DME of Florida
TIN#:	TIN#: xxxxxxxxxxx
Phone#:	Phone#: (xxx)xxx-xxxx
Fax#:	Fax #: (xxx)xxx-xxxx

Hospital/ASC Requested (please check one) Inpatient Outpatient Observations Amb Surg Center
 Date of Service (if already scheduled): _____

CPT Code	Description	CPT Code	Description

Home Health Services **Must be homebound for Medicare to cover**
 Date(s) of Service: _____
 SN # of visits: PT # of visits: _____ OT# of visits: _____ MSW # of visits: _____ HHA # of visits: _____ SLT# of visits: _____
 Reason for visits: _____

Outpatient Rehab
 Date(s) of Service: _____
 PT # of visits: _____ OT #of visits: _____ SLT # of visits: _____
 Reason or codes for rehab: _____

DME Requests:

Code	Description	Code	Description
K0010	Standard power wheelchair		

Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting

CPT Code	Description	CPT Code	Description

Office Visits (Check One) Non-Par Injections Rad Tx Chemo Pain Mgmt **Length of treatment** _____ **days**

Code	Description	# of Services	Code	Description	# of Services

PRE-CERTIFICATION FORM

Example

Office Visits



Freedom Health Pre-Certification Request Form

Phone: (888) 797-0947 Fax: xxx-xxx-xxxx

Do not make an appointment until authorization has been received. If your physician feels that waiting for a decision under the Medicare allowed timeframe of 14 days would place the patient's life, health, or ability to regain maximum function in serious jeopardy then call the UM department and ask for an expedited review.

Please see back for more information.

Date: 5/2/08 Status: Stat(Call) <input type="checkbox"/> Urgent (3-5 days) <input checked="" type="checkbox"/> Standard (7-14 days)	PCP/Ordering MD Requested by <input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider James Smith
Member Name: Doe, John	Phone #: (xxx)xxx-xxxx
Member ID: Pxxxxxxx-01	Fax#: (xxx)xxx-xxxx
Dx ICD9 Code(s): 715.16	TIN#: xxxxxxxxxxx
Dx: Description: Osteoarthritis	Office Contact Person: Emily Ext: 2224

Facility Requested (No Abbreviations) Name:	Physician/Provider/Agency Requested (No Abbreviations) Name: Dr. Samuel Bones
TIN#:	TIN#: xxxxxxxxxxx
Phone#:	Phone#: (xxx)xxx-xxxx
Fax#:	Fax #: (xxx)xxx-xxxx

Hospital/ASC Requested (please check one) Inpatient Outpatient Observations Amb Surg Center
Date of Service (if already scheduled): _____

CPT Code	Description	CPT Code	Description

Home Health Services **Must be homebound for Medicare to cover**
Date(s) of Service: _____
 SN # of visits: PT # of visits: _____ OT# of visits: _____ MSW # of visits: _____ HHA # of visits: _____ SLT# of visits: _____
Reason for visits: _____

Outpatient Rehab
Date(s) of Service: _____
 PT # of visits: _____ OT #of visits: _____ SLT # of visits: _____
Reason or codes for rehab: _____

DME Requests:

Code	Description	Code	Description

Imaging Services MRI, MRA, PETs, Nuclear Testing and all radiology done in hospital outpatient setting

CPT Code	Description	CPT Code	Description

Office Visits (Check One) Non-Par Injections Rad Tx Chemo Pain Mgmt **Length of treatment 3 weeks**

Code	Description	# of Services	Code	Description	# of Services
J7321	Hyalgan injection	1x/week			
99213	Office visit	3			