Request for Certification

- All fields below are necessary to begin a certification request. Failure to provide all requested information may delay your request for certification. Submit fax to 866-229-0028.
- ***Please include applicable chart notes, laboratory results and radiology findings with this request.***

Patient Information

Name:	DOB:
Address:	Phone #:
Member ID #:	Group #:

Request **All requests are considered non-urgent unless otherwise indicated**

Date of Request:	Date of Service:
Primary Diagnosis Code:	Additional Diagnosis Codes:
Medication Requested: (include Drug/strength/dose)	

Ordering Physician Information

Name:	Specialty:
TIN or NPI:	
Address:	Phone #:
City/State/Zip:	Fax #:
Contact Name:	Contact Phone #:

Rendering Facility Information

Name:
Address:
City/State/Zip:
TIN or NPI:
Phone #:
Fax #:

Requestor

Name:	Phone #:
From Where:	Fax #:

Please remember that certification of services as medically necessary is not a guarantee of benefit payment.
Reimbursement of services provided is based on the provisions outlined in the benefit plan and the member employment status (if applicable) at the time services are rendered. Patients and providers are encouraged to verify plan benefits by calling the telephone number located at the top of the Member's ID Card.