OFF ISLAND PRE-CERTIFICATION MANAGEMENT FORM

PLEASE HAVE MEMBER PRESENT ID CARD FOR OTHER INSURANCE CARRIER

STAT	ROUTINE	SCHED	DATE:

PATIENT NAME: DATE OF BIRTH:

MEMBER ID NO.: PLAN/EMPLOYER:

ON-ISLAND CONTACT PHONE NO.:(h) (w) (cell)

OFF-ISLAND CONTACT PHONE NO.: email address:

OTHER INSURANCE: POLICY NO.:

SLMC TMC CHH Kameda TAH Sahmyook HKAH PHS _____ ECU _____

PRIMARY CARE MD IN GUAM: RECORDS ATTACHED: Yes No

DIAGNOSIS/CHIEF COMPLAINT/SYMPTOMS/DURATION:

FACILITY/HOSPITAL:

TENTATIVE DEPARTURE DATE:

REQUESTED APPOINTMENT DATE:

NUMBER OF DAYS SPENT OFF ISLAND PRIOR TO THIS DEPARTURE FOR THIS POLICY YEAR:

FOR STAYWELL USE ONLY

Date of Inquiry	Premium PPE/Month	UM/CCM Staff	Date sent to Enrollment	Enrollment PPE/Month OK	Enrollment Staff	Date Received	Authorization Valid Through

ACTUAL DEPARTURE DATE:

CALCULATION OF OI DAYS: