

ON-ISLAND PRE-CERTIFICATION FORM

PATIENT INFORMATION			
Last Name:	First Name:	Date of Request:	
Member #:	-	Date of Birth:	
Address:	Telephone: () -	Work Phone: () -	
	Other Insurance:		
PHYSICIAN INFORMATION			
Primary Physician:	Telephone: () -	Fax: () -	
Consulting Physician:	Telephone: () -	Fax: () -	
Setting:	In-Patient <input type="checkbox"/>	Out- Patient <input type="checkbox"/>	Ambulatory Surgery <input type="checkbox"/> Others <input type="checkbox"/>
Date, Time, and Place of Service:			
PLEASE COMPLETE THE FOLLOWING & ATTACH SUPPORTING DOCUMENTS FOR SURGERY/PROCEDURE/IMAGING STUDY			
IMAGING STUDY/PROCEDURE/SERVICE REQUESTED and CPT Code:			
PRE-OPERATIVE/PRE-PROCEDURE DIAGNOSIS and ICD Code:			
PERTINENT SIGNS/SYMPTOMS:			
TREATMENT RECEIVED AND DURATION:			
RESPONSE TO TREATMENT:			
COMMENTS (pls. include significant past medical history and/or co-morbidity):			

PHYSICIAN'S SIGNATURE

TO BE COMPLETED BY STAYWELL			
Subscriber's Name: _____		Effective Date: _____	
Employer/Group/Plan: _____		Deductible Amount: _____	
Periodic Screening/APE Benefit Applies:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Colon Cancer Screening Benefit Applies:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Chronic Orthopedic Condition Limitation Applies:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Approved	<input type="checkbox"/> PRE-CERTIFICATION NUMBER: _____		
<input type="checkbox"/> PROCEDURE REQUESTED DOES NOT REQUIRE PRE-CERTIFICATION			
<input type="checkbox"/> PENDING PHYSICIAN CLARIFICATION	Please call StayWell Informed Choice Department at 671-477-5091 ext. 403. If no communication is received from your office by _____, payment for the requested service shall be denied.		
<input type="checkbox"/> DENIED	Reasons:	ALTERNATIVE PROCEDURE/SERVICES PAYABLE BY THE PLAN:	
	<input type="checkbox"/> Not a covered benefit	1. _____	
	<input type="checkbox"/> Does not meet criteria	2. _____	
<input type="checkbox"/> Others			
COMMENTS:			
Processed By: _____		Date: _____	

NOTE: This Pre-Certification Form does not guarantee payment as the final claim approval is subject to the member's health plan benefits, exclusions, policy provisions and eligibility at the time of service.