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 ☐	Out- Patient ☐	Ambulatory Surgery ☐	Others ☐

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: ☐ Yes ☐ No

Colon Cancer Screening Benefit Applies: ☐ Yes ☐ No

Chronic Orthopedic Condition Limitation Applies: ☐ Yes ☐ No

☐ Approved ☐ PRE-CERTIFICATION NUMBER:

☐ PROCEDUE REQUESTED DOES NOT REQUIRE PRE-CERTIFICATION

☐ PENDING PHYSICIAN CLARIFICATION

Please call StayWell Informed Choice Department at 671-477-5091 ext. 1140. If no communication is received from your office **after five working days**, payment for the requested service shall be denied.

☐ DENIED

Reasons:
- ☐ Not a covered benefit
- ☐ Does not meet criteria
- ☐ Others

ALTERNATIVE PROCEDURE/SERVICES PAYABLE BY THE PLAN:

1. _____
2. _____

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.