STAYWELL INSURANCE 520 ROUTE 8 MAITE, GUAM 96910
TELEPHONE: (671) 477-5091 Ext. 1142,1143,1140 FACSIMILE: (671) 477-2464

ON- ISLAND PRECERTIFICATION FORM

Patient Name: ____________________ Date of Request: ____________________

Member #: ____________________ Date of Birth: ____________________

Address: ____________________ (Tel) __________ (Work) __________

Other Insurance: ____________________

Primary Physician: ____________________ (Tel) __________ (Fax) __________

Consulting Physician: ____________________ (Tel) __________ (Fax) __________

Setting: In-Patient ☐ Out- Patient ☐ Ambulatory Surgery ☐ Others ☐

Date , Time, and Place of Service: ____________________

PLS. 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): ____________________

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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** **PRECERTIFICATION NUMBER**: ____________________

☐ **PROCEDURE REQUESTED DOES NOT REQUIRE PRECERTIFICATION.**

☐ **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.

☐ **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 Precertification 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.

Revised date: 9/4/2018 csv