MEDICAL PRECERTIFICATION (PC) REQUEST FORM

For Patient's Attending Doctor – please complete this form in its entirety and attach clinical documents to support Medical Necessity.

Send PC request and supporting documentation to:

Email precert@mysurego.com or **Fax** 1-888-835-8416 attention PreCert Medical Team

Submit all specific clinical information that supports your medical necessity review. Failure to complete this form and submit all documents will result in delay of review or denial of coverage.

Patient information: (refer to ID card)

Patient Name_____ Patient Insurance ID #_____
Date of Birth_____ Phone Number_____

Requesting healthcare professional's information (HCP):

Requesting HCP Name _____ NPI_____
Address _____
Phone_____ Fax _____
Email_____

Facility Information:
Facility name_____ Contact Info.: _____

Service information:
Inpatient _____ Outpatient _____Other (specify) _____
Planned Date of Service/s _____
Diagnosis code(s) Primary _____ _____ _____ _____
Diagnosis code(s) Secondary _____ _____ _____ _____

Procedure code (CPT/HCPCS)	Date of Service	Modifier	Units

Drugs/Injectables: _____

Pre-certification is a general determination of Medical Necessity only. Pre-certification is not an assurance, authorization, preauthorization, or verification of Treatment or coverage, a verification of benefits, or a guarantee of payment.

_____

ADDITIONAL DETAILS: For the patient-specific information requested below, if needed, you may attach separate documents.

The patient's symptoms:

_____

_____

_____

Your clinical findings for the patient: _____

_____

_____

Any conservative management, with outcome, related to this patient's condition: _____

_____

_____

Anticipated outcome of the proposed treatment: _____

_____

_____

If inpatient, what is the patient's expected length of stay? _____

For the person completing the form:

Name: _____**Signature:** _____

Date: _____/_____/_____ **Contact #:** _____

Where should the response be sent to:

Email - _____

E-fax - _____

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