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 Fax: (671) 472-6375
 Email: providers@netcarelifeandhealth.com

Authorization No: _____

PRE-CERTIFICATION REQUEST FORM FOR SERVICES OUTSIDE OF GUAM

Pre-Certification is required for all in-patient confinements, outpatient surgery, diagnostic testing, radiation therapy, sleep evaluation, hyperbaric oxygen treatments, home health care, private duty nursing, physical therapy & DME.

All Pre-Certification Form (s) must be completed by the attending physician or nurse and faxed to NetCare at least 48 hours prior to the services being rendered. We ask for your adherence and compliance with this policy.

Failure to obtain pre-certification approval for those services or benefits requiring prior authorization from NetCare may result in a disallowance of up to 50% of charges.

Please note that pre-certification is only a determination of medical necessity, not an assurance of coverage, or guarantee of payment.

Member's Name (Last, First, M.I.)	Date of Birth	Sex: Male/Female	Date of Request:
Member's NetCare ID No.	Subscriber Name (Last, First, M.I.)	Benefit Plan	Effective Date:
Member's Mailing Address	Relationship to Subscriber	On Island Contact #	Off Island Contact #
Name of Requesting Provider / PCP	Provider Tax ID #	Office Tel#:	Office Fax #:

TYPE OF PROCEDURE REQUESTED, LIST CPT CODES (REQUIRED FOR REVIEW):

Diagnosis/ICD-9 Codes/Clinical Findings (Please attach clinical notes, laboratory and/or imaging results):

<input type="checkbox"/> Outpatient Surgery (Indicate type of surgery):	Surgery Assistant: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> In-Patient (Hospital, Rehab, SNF)	
<input type="checkbox"/> MRI/CT Scan/Ultrasound/Echocardiogram/Audiological evaluation or other Diagnostic Procedures (Please indicate):	
<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Home Health Care
<input type="checkbox"/> Other Procedures (Please specify):	

Provider/Physician/Clinic Rendering Service: Name: _____ Address: _____ Tax ID Number (required): _____ Tel #: _____ Fax #: _____ Date(s) of Service: _____ <input type="checkbox"/> First Health Network <input type="checkbox"/> COC <input type="checkbox"/> PAR <input type="checkbox"/> NON-PAR	Facility where service is to be performed: Name: _____ Address: _____ Tax ID Number (required): _____ Tel #: _____ Fax #: _____ Date(s) of Service: _____ <input type="checkbox"/> First Health Network <input type="checkbox"/> COC <input type="checkbox"/> PAR <input type="checkbox"/> NON-PAR
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FOR NETCARE USE ONLY:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> Disapproved	<input type="checkbox"/> Modified	<input type="checkbox"/> Treatment Plan Requested
_____	Expires on: _____			
Authorized by: _____	Date _____			

Comments: _____

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