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**PRIOR AUTHORIZATION / PRE-CERTIFICATION FORM**

Authorization No.: \_\_\_\_\_

**Please note that pre-certification is only a determination of medical necessity, not an assurance of coverage, verification of benefits, or a guarantee of payment. This is subject to member's eligibility at the time of service. 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.**

**REGULAR** (w/in 24-72 hrs.)                       **URGENT**

**Commercial/PPO**                       **Continental – HMO**                       **Continental – PPO**                       **Advantage** \_\_\_\_\_

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Policy # \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Home # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Requesting Provider Name \_\_\_\_\_ TIN # \_\_\_\_\_ Contact Person \_\_\_\_\_  
 Office Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Alt. Phone # \_\_\_\_\_  
 Facility Name \_\_\_\_\_ TIN # \_\_\_\_\_ Contact Person \_\_\_\_\_  
 Office Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Alt. Phone # \_\_\_\_\_  
 ICD9 Code(s) \_\_\_\_\_ CPT Code(s) \_\_\_\_\_  
 Date of Service: \_\_\_\_\_ Out-Patient Setting:  Surgi-Center  Clinic  
 In-Patient:  Yes  No Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_ Requested In-Patient Days: \_\_\_\_\_  
 If Home Care Facility, Purpose of Referral \_\_\_\_\_ Requested # of Visits: \_\_\_\_\_  
 Comments \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE OF REQUESTING PHYSICIAN

\*\*\*\*\* **BELOW TO BE COMPLETED BY NETCARE** \*\*\*\*\*

Current Eligibility \_\_\_\_\_ Related Referral Authorization # \_\_\_\_\_  
 Comments: \_\_\_\_\_

PCP on Panel ?  Yes  No                      Specialist on Panel?  Yes  No                      Facility on Panel?  Yes  No

**PENDED for:**                       **Additional Info. Requested**                       **NetCare Medical Director's Review**

**APPROVED:**     **AUTHORIZED**     **MODIFIED**    Authorization #: \_\_\_\_\_  
 Procedure(s): \_\_\_\_\_ Co-Payment: \_\_\_\_\_  
 Approved by: \_\_\_\_\_ Date Approved: \_\_\_\_\_ Expires on: \_\_\_\_\_ # of In-Pt Days Authorized: \_\_\_\_\_

**DISAPPROVED:**     **NOT Authorized**    Tracking #: \_\_\_\_\_  
 Member Not Eligible     Out-of-Network Facility     Out-of-Network Provider     Medical Necessity Not Established     Plan Benefits Exhausted     Not A Covered Benefit  
 Signed by: \_\_\_\_\_ Date Signed: \_\_\_\_\_ Expires On: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

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