



PRE-CERTIFICATION / AUTHORIZATION FORM

Fax to: 954-767-5649

Request Priority (circle one): Stat Urgent Routine

Today's Date: _____

LOB (circle one): PPUC PSN CMS Other

Member Information:

Member Name: _____ DOB: _____
Member SS #: _____ Member ID #: _____
Member Address: _____
Member Phone #: _____

Physician/Provider Information:

Office Contact Name: _____ Phone #: _____
Services requested by (check one): PCP ___ Specialist ___
PCP Name: _____ PCP Phone #: _____ PCP fax #: _____
Specialist: _____ Phone #: _____ Fax #: _____
Specialty: _____ Address: _____
Requesting Physician Signature: _____ Date: _____

Clinical Information:

Diagnosis (ICD-9): _____
Clinical Summary/findings: _____
(Please attach relevant office records, test results, attempted treatment, second opinion and consults)

Requested Services:

Type of service (Circle one): Inpatient Outpatient Office

Consultation only: _____ Follow-up: _____ Number of visits requested (circle): 1 2

Requested Services (Please provide CPT codes): _____

Name of Facility: _____ Estimate Length of Stay: _____

For Best Choice Plus Internal Use Only

Approved Date: _____ Authorization #: _____ (Use within 60 days)
Pended: Date: _____ Reason: _____
Denied: Date: _____ Reason: _____

Statement to provider: This authorization is for medically necessary services only. Payment is contingent on services being authorized, services being a covered benefit, coordination of benefits and patient eligibility at the time of service. Additionally, it is important that a report of the treatment provided or service(s) recommended be completed on this member and forwarded to the primary care physician.

*****NOTICE*****

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