Medical Pre-Certification Request Form

Phone: 833-380-9080 **Fax:** (682) 477-3868 **Email:** precert@onesharehealth.com
(all emails containing PHI should be sent securely)

All fields are REQUIRED. An incomplete request form will delay the pre-certification process. Completion of this form is solely for the purposes of **initiating** a pre-certification request. Completion of the form does **NOT** mean that pre-certification has been completed.

☐ **Standard Request:** allow 10-14 business days
☐ **Standard Request/Quick Response:** Process quickly due to date of service/scheduling constraints

Pre-Scheduled Date of Service: _____ **Auth Date needed by:** _____

Definition of Expedited/Urgent; waiting for a decision under Standard timeframe:

☐ Could place the enrollee's life, health, safety (of member or others), or ability to regain maximum function in serious jeopardy.
☐ In the opinion of the practitioner, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

☐ **Expedited Request** **Physician Signature** _____

Member Information		**Pre-Cert #:** (internal use only)
Last Name:	**First Name:**	
ID #	Date of Birth	Gender F ☐ M ☐
Requesting Provider Information (Primary Care or Specialist)		
Name:	Provider # or Tax ID:	NPI:
Telephone/Ext:	Fax:	Contact Person:
Service Provider or Facility (e.g., Specialist, PCP, Hospital, Surgery Center, etc.) **For Non-Par providers, please include: Name, Address, Tax ID, NPI, Phone /Fax Numbers & Contact Person.**		
Name:	Provider # or Tax ID:	NPI:
Telephone/Ext:	Fax:	Contact Person:

Requested Service: Please Include supporting chart notes, Diagnostic tests & Lab Values when appropriate.
(A 24-month pre-existing look back from member effective date, applies to all OneShare programs)

☐ In Patient Admission	☐ In Patient Rehabilitation	☐ Chemotherapy/Radiation	☐ Transplant
☐ Outpatient Surgery	☐ Home Health	☐ Skilled Nursing	☐ Other*

Diagnosis: ICD-10 Code and Description		
Code:	Code:	Code:
Description:	Description:	Description:
Procedure: CPT Code/HCPCS and Description		
Code:	Description:	
Code:	Description:	
Code:	Description:	
***Provide additional information or changes to be made to an existing authorization below:**		

A PRE-CERTIFICATION DOES NOT GUARANTEE PAYMENT AND DOES NOT SUPERSEDE ANY PROGRAM GUIDELINES OR LIMITS. CONSIDERATIONS, SUCH AS MEMBERSHIP STATUS, PRE-EXISTING CONDITIONS, AND PROGRAM LIMITATIONS ARE CONSIDERED WHEN DETERMINING SHARING ELIGIBILITY.