J.P. FARLEY CORPORATION
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CONFIDENTIAL

PRECERTIFICATION REQUEST FORM

To: ______________________________ From: ______________________________ Updated: ______________

This confidential information is important for ongoing plan payment consideration.

PATIENT & HEALTH PLAN INFORMATION		
Patient Name (First M.I., Last):	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY):
Address:	City:	State: Zip:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Group #:	Group Name:	Policyholder (Subscriber):

ORDERING PHYSICIAN			
Full Physician Name:	Specialty/Degree:		
Address:	City:	State:	Zip:
Office Phone: ( ) -	TIN (Tax Identification Number):		
Fax: ( ) -	Is the Physician in the ____________ Network? ☐ Yes ☐ No		

HOSPITAL / FACILITY / SPECIALIST PROVIDING SERVICE			
Facility Name:			
Address:	City:	State:	Zip:
Office Phone: ( ) -	TIN (Tax Identification Number):		
Fax: ( ) -	Is the Facility in the ____________ Network? ☐ Yes ☐ No		

* ** * **FAX** completed form and clinical notes/treatment plan to **440-250-4301**, Attention Case Manager. * ** *

*****PLEASE PROVIDE COPIES OF CURRENT PROGRESS NOTES, MEDICATIONS, AND DIAGNOSTIC TESTING RESULTS.*****

- Explain chief complaint (including date of injury)
- Previous treatment and Progress notes
- History of symptoms
- Diagnostic tests with results
- For medication precertification include prescription and letter of medical necessity
- List ALL surgeries, procedures, test results, pathologies, consultations, medications, therapies & treatments.

Diagnosis ICD-9 Code(s) & Description:

Procedure / CPT Code(s) & Description:

☐ Inpatient ☐ Outpatient ☐ Diagnostic Test ☐ Medication ☐ Therapy ☐ Specialty Referral ☐ DME ☐ Other:______________

Procedure Date(s) (MM/DD/YYYY):

NOTES & ADDITIONAL REMARKS:

CONNECTED CARE SERVICES CONTACT - Please contact Case Manager for questions/concerns/problems.

OFFICE USE	Authorization Number:	Approved By:	Date (MM/DD/YYYY):
	Precertification Needed? ☐ Yes ☐ No	Benefits Checked? ☐ Yes , by (Initial):	

***Disclaimer:** Certification does not guarantee plan payment. All plan payments are subject to the claim processor's determination of eligibility and coverage at the time the services are rendered. All applicable plan provisions, including network participation, and reasonable and customary charges will apply to any plan payments. **Please note:** This information and facsimile transmission is intended only for the address named above. It contains information that is confidential or otherwise protected from use and disclosure. If you are not the intended recipient, or agent responsible for delivering it to the intended recipient, you are hereby notified that any review, disclosure, copying or dissemination of this transmission or the taking of any action in reliance on its contents, or other use is strictly prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for its return to us.* CC.CC.PreCert.0020