Prominence®
Health Plan

MEDICARE PRE-CERTIFICATION REQUEST FORM

All REQUIRE MEDICAL RECORDS TO BE ATTACHED

Phone: 855-969-5884 Fax: 813-513-7304

Instructions:
This form is for pre-certification requests which will be processed as quickly as possible depending on the member's health condition.
Do not write STAT, ASAP, Immediate, etc. on this form. Please complete appropriate sections below.

Complete this section for expedited requests ONLY. Medicare's definition of expedited is defined as one where "applying the standard time for making a determination could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function."

If your PHYSICIAN feels the member meets the definition of expedited above, have your physician document his/her reason below:

_____

_____

Complete remainder of form for ALL requests.

Member Information

Name:_____ Date of Birth: _____ Plan ID#:_____

Requesting Provider Information

Requesting provider name:_____ TIN#: _____

Phone: (____)_____ Fax: (____)_____ Contact Person:_____ Ext._____

Please provide a short clinical statement to support your request:

_____

_____

_____

Facility Requested (No Abbreviations)	**Provider Requested** (No Abbreviations)
Name:_____	Name:_____
TIN#: _____ ☐ Non-Par	TIN#: _____ ☐ Non-Par
Phone: (_____)_____ Fax: (_____)_____	Phone: (_____)_____ Fax: (_____)_____

Date of Service:	**Diagnosis:**	**ICD-10 Code(s):**
	Diagnosis:	**ICD-10 Code(s):**

Service Requested: Check appropriate request(s)

If the service doesn't fall into one of these categories, please submit your request using a Referral Request Form.

- ☐ Abortions
- ☐ Acute Rehabilitation Facility
- ☐ Acupuncture (after 10 visits)
- ☐ Ambulance (for non-emergency transport)
- ☐ Ambulatory Surgical Center (ASC) Services
- ☐ Chemotherapy
- ☐ Clinical Trials (not approved by Medicare)
- ☐ Cosmetic Procedures
- ☐ Dental Services (Medicare-covered)
- ☐ Dialysis
- ☐ DME/Orthotics/Prosthetics > $500 (see * below)
- ☐ Enteral Feedings
- ☐ Experimental/Investigational Procedure
- ☐ Genetic Testing/Blood Products
- ☐ Home Health Services
- ☐ Hospice ** **Notification only**
- ☐ Hyperbaric Oxygen Therapy
- ☐ Implantable pump/device or stimulator
- ☐ Injectables/Infusion Therapy
- ☐ Injections > $100 billed charges per unit
- ☐ Inpatient Hospital
- ☐ Medical Nutrition Education
- ☐ MOHS Procedure (Dermatology)
- ☐ Non-Participating Provider
- ☐ Obstetrical Care
- ☐ Outpatient Hospital (Excludes Ultrasounds, X-rays & Labs)
- ☐ Pain Management
- ☐ Radiation Therapy

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- ☐ Radiology/Diagnostic Test: CT, CTA, MRA, MRI, Nuclear Med Cardiac, PET, Pill, MUGA, Radiation Oncology, Medical Oncology, Virtual Colonoscopy or Endoscopy and 3-D Ultrasound
- ☐ Rehab Cardiac/Pulmonary/Respiratory
- ☐ Rehab Therapy (Chiro, PT, OT, SP) – any outpatient hospital and any office therapy > than 10 visits.
- ☐ Skilled Nursing Facility
- ☐ Sleep Studies
- ☐ Sterilizations
- ☐ TMJ Joint treatment
- ☐ Transplant
- ☐ Wound Care (outpatient hospital only)

CPT or HCPC Code(s)	**Description**	**# of Visits/Injections**

*DME > $500 if purchased or > $38.50 per month if rented. Includes all wheelchairs, hospital beds, CPAPs, BiPAPs, nerve and bone growth stimulation devices and oxygen, as well as TENS devices, wound care/wound vacuums and related supplies, repairs, miscellaneous codes and all Medicare non-covered items.