Chesapeake Employers Insurance

PRECERTIFICATION FORM (General/Therapy/Surgery)

(Fax to 410-494-2079)

(If not previously submitted, please include supporting documentation.)

PATIENT INFORMATION

Last Name:	**First Name:**	
Claim #:	**DOB:**	**Injury Date:**

PERSON SUBMITTING REQUEST

Last Name:	**First Name:**	**Date:**
Phone:	**Fax:**	**Email:**

PROVIDER INFORMATION

Ordering Provider:		**Phone:**
Fax:	**Email:**	
Provider of Service:		**Phone:**
Fax:	**Email:**	
Tax ID:	**Vendor #:**	**Service Date(s):**

BODY PART(S)

1.	**☐ Right ☐ Left ☐ Bilateral**	**3.**	**☐ Right ☐ Left ☐ Bilateral**
2.	**☐ Right ☐ Left ☐ Bilateral**	**4.**	**☐ Right ☐ Left ☐ Bilateral**

Additional info:

GENERAL SERVICES

Type:	**Contrast: ☐ With ☐ Without ☐ Both**
Durable Medical Equipment (DME):	
Supplies/Quantity:	
Purpose:	

THERAPY ☐ INITIAL ☐ SUBSEQUENT

Service Type:

# Requested:	**Date Range:**		**Frequency:**
Visits to Date:	**# Missed:**	**Progressing: ☐ Yes ☐ No**	**Estimated discharge date:**

SURGERY/PROCEDURE/FACILITY

Procedure:

☐ Right ☐ Left ☐ Bilateral	**☐ Outpatient ☐ Inpatient ☐ Office ☐ Other:**	**Service Date:**

Facility Name:

Facility tax ID:	**Phone:**	**Fax:**

SERVICE CODES

ICD-10(s):	**HCPCS:**
CPT(s):	
Additional Code(s):	

ADDITIONAL INFORMATION

Chesapeake Employers' Insurance Company
8722 Loch Raven Boulevard • Towson, Maryland, 21286-2235 • 410-494-2000 • 1-800-264-4943 • www.ceiwc.com