



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.	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	3.	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
2.	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	4.	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral

Additional info:

GENERAL SERVICES

Type:	Contrast: <input type="checkbox"/> With <input type="checkbox"/> Without <input type="checkbox"/> Both
Durable Medical Equipment (DME):	
Supplies/Quantity:	
Purpose:	

THERAPY INITIAL SUBSEQUENT

Service Type:			
# Requested:	Date Range:	Frequency:	
Visits to Date:	# Missed:	Progressing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Estimated discharge date:

SURGERY/PROCEDURE/FACILITY

Procedure:		
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	<input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Office <input type="checkbox"/> Other:	Service Date:
Facility Name:		
Facility tax ID:	Phone:	Fax:

SERVICE CODES

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

ADDITIONAL INFORMATION
