NetCare
Life and Health Insurance

424 West OBrien Drive
Julale Center, Suite 200
Hagatna, Guam 96910
Tel: (671) 472-3610, ext. 245 or 250
Fax: (671) 472-6375 or (671-472-3615
Email: providers@netcarelifeandhealth.com

Eff - Nov/2014

Authorization #:_____

PRE-CERTIFICATION FORM

Please note that pre-certification is only a determination of medical necessity, not an assurance of coverage, verification of benefits, or a guarantee of payment. This is subject to member's eligibility at the time of service. Failure to obtain pre-certification approval for those services or benefits requiring prior authorization from NetCare may result in a disallowance of up to 50% of charges.

☐ **REGULAR (within 24 hrs. - 72 hrs.)** ☐ **URGENT APPTMT ON** _____

☐ **Commercial / PPO** ☐ **Commercial - Advantage HMO / POS** ☐ **United Airlines (Plan** _____)

☐ **Judiciary HSA 2000** ☐ **Judiciary PPO 1000** ☐ **GovGU HSA 2000** ☐ **GovGU PPO 1500**

Patient Name _____ D.O.B. _____ Member ID # _____

Insured Name _____ Home# _____ Cell Phone # _____

Requesting Provider Name _____ TIN # _____ Contact Person _____

Office Phone # _____ Fax # _____ Alt. Phone # _____

Facility Name _____ TIN # _____ Contact Person _____

Office Phone # _____ Fax # _____ Alt. Phone # _____

ICD9 Code(s) _____ CPT Code(s) _____

Date of Service: _____ Out-Patient Setting: ☐ Surgi-Center ☐ Clinic

In-Patient: ☐ Yes ☐ No Admit Date: _____ Discharge Date: _____ Requested In-Patient Days: _____

If Home Care Facility, Purpose of Referral Requested # of Visits: _____

Comments: _____

_____ _____

SIGNATURE OF REQUESTING PHYSICIAN

**********BELOW TO BE COMPLETED BY NETCARE **********

Current Eligibility _____ Related Referral Authorization # _____

Chart Notes Requested: ☐ Yes ☐ No Date Requested: _____ Date Received: _____

Comments: _____

PCP on Panel ? ☐ Yes ☐ No Specialist on Panel? ☐ Yes ☐ No Facility on Panel? ☐ Yes ☐ No

PENDED for: ☐ Additional Info. Requested ☐ NetCare Medical Director's Review

APPROVED: ☐ AUTHORIZED ☐ MODIFIED Authorization #- _____

Procedure(s): _____ Co-Payment: _____

Approved by: _____ Date Approved: _____ Expires on: _____ # of In-Pt Days Authorized: ____

DISAPPROVED: ☐ NOT Authorized By: _____ Date: _____

☐ Member Not Eligible ☐ Out-of-Network Facility ☐ Out-of-Network Provider ☐ Medical Necessity Not Established ☐ Plan Benefits Exhausted ☐ Not A Covered Benefit

Comments: _____

_____

_____