NetCare
Life & Health Insurance

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LOG: **Authorization No:**

PRE-CERTIFICATION REQUEST FORM FOR SERVICES OUTSIDE OF GUAM

Pre-Certification is required for all in-patient confinements, outpatient surgery, diagnostic testing, radiation therapy, sleep evaluation, hyperbaric oxygen treatments, home health care, private duty nursing, physical therapy & DME.

All Pre-Certification Form (s) must be completed by the attending physician or nurse and faxed to NetCare at least 48 hours prior to the services being rendered. We ask for your adherence and compliance with this policy.

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.

Please note that pre-certification is only a determination of medical necessity, not an assurance of coverage, or guarantee of payment.

Member's Name (Last, First, M.I.)	Date of Birth	Sex: Male/Female	Date of Request:
Member's NetCare ID No.	Subscriber Name(Last, First, M.I.) SSN#	Benefit Plan	Effective Date:
Member's Mailing Address	Relationship to Subscriber	On Island Contact #	Off Island Contact #
Name of Requesting Provider / PCP	**Provider Tax ID #**	**Office Tel#:**	**Office Fax #:**

TYPE OF PROCEDURE REQUESTED, LIST CPT CODES (REQUIRED FOR REVIEW):

Diagnosis/ICD-9 Codes/Clinical Findings (Please attach clinical notes, laboratory and/or imaging results):

☐ Outpatient Surgery (Indicate type of surgery):

☐ In-Patient (Hospital, Rehab, SNF)

Surgery Assistant: ☐ Yes ☐ No

☐ MRI/CT Scan/Ultrasound/Echocardiogram/Audiological evaluation or other Diagnostic Procedures (Please indicate):

☐ Durable Medical Equipment ☐ Home Health Care ☐ Other Procedures (Please specify):

Provider/Physician/Clinic Rendering Service:

Name: _____

Address: _____

_____

Tax ID Number (required):_____

Tel #: _____ **Fax #:** _____

Date(s) of Service: _____

☐ First Health Network ☐ COC ☐ PAR ☐ NON-PAR

Facility where service is to be performed:

Name: _____

Address: _____

_____

Tax ID Number (required):_____

Tel #: _____ **Fax #:** _____

Date(s) of Service: _____

☐ First Health Network ☐ COC ☐ PAR ☐ NON-PAR

FOR NETCARE USE ONLY: ☐ **APPROVED** ☐ **Disapproved** ☐ **Modified** ☐ **Treatment Plan Requested**

Expires on:

_____ _____ _____ _____ _____

Authorized by: **Date** **Eligibility Verified by:** **Date**

Comments: _____