Date of Request: ____/____/______

PRE-CERTIFICATION FORM

Patient Name: ________________________________ **Member ID #** ____________________________

Patient DOB: ____/____/______ Patient Phone: (___) ____-_______ Different Last Name: ____________________

Ordering Physician: ______________________________ Address: ____________________________________

City: ____________________ State: ____ Zip _______ Phone: (___) ____-_______ Fax: (___) ____-________

Contact Person: ____________________________ Fax: ( )___-____ Phone: (___) ____-_______ Ext: ______

Physician Tax ID#: ______________________ NPI#: ______________________________________

FACILITY FOR SERVICE: Fax: ( ) -

Name: ____ Phone: (___) ____-_______

Address, City, State: ____

Facility Tax ID: ____________________________ Facility NPI#: _________________________________

Date of Service: ____/____/_____ PLEASE CHECK CORRECT SERVICE BELOW

SERVICE TYPE: Physical Therapy ____ Occupational Therapy ____ Speech Therapy ____ Brace ____

Chiro ____ Genetic Testing ____ OP Surgery ____ Diagnostic Testing ____ Sleep Study ____

Radiology ____ DME ____ Prosthetics/Orthotics ____ CPAP ____ Elective IP Surgery ____

Other ____

Diagnosis	**ICD10**

CPT CODES	**Description**	**Quantity Requested**	**Date Range Start and End**

PLEASE PROVIDE ALL CLINICAL DOCUMENTATION FOR PROCESSING.

FAX TO: MMFAX@CUSTOMDESIGNBENEFITS.COM OR FAX TO 513-389-2997

This authorization is not a guarantee of payment. Plan benefits are based on the patient's eligibility at the time of service. For questions on eligibility and benefits call 513-598-2929/800-598-2929

MM Form 2018

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