Precertification Request Form

*****Please totally complete each line or the form will be returned before processing*****

Patient Name: _____Insurance ID#_____DOB: _____

Patient Address: _____Patient Phone# _____

Insured Name: _____Employer: _____

DOS/Admission: _____ **Please check**: Inpatient _____ Outpatient _____

Provisional Diagnosis: _____ **High Risk Dx: Circle Yes No** ICD10: _____

Planned Procedure: _____ CPT(s): _____

Referring Physician _____ *****Precertification number will not be issued without this*****

Admitting Physician/Ordering Provider: _____ Provider Phone: _____

Provider Email or Fax: _____ Provider Tax ID #: _____

Facility of Procedure: _____ Facility Contact Name: _____

Facility Email or Fax:_____ Facility Tax ID #: _____

Please provide corresponding clinicals to support this request.

Please note: Normal precertification turnaround – 2 business days

EMAIL COMPLETED FORM TO
precert@sharppho.com

******This precertification does not guarantee that the service requested is a covered benefit, nor does it guarantee payment of claims. For eligibility, please contact the third party administrator.******

For Office Use Only – Case #:_____Precert #: _____

Reviewed: _____Date: _____

TR: _____Discharged: _____TPA Notified: _____

Case Agreement:_____Referral: _____