

***PRECERTIFICATION REQUEST FORM***

**This form must be completed in its entirety before processing can be completed.**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder/Insured Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOS/Admission \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please Check One - Inpatient \_\_\_\_\_\_\_\_\_ Outpatient \_\_\_\_\_\_\_\_\_\_\_**

**Provisional Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Risk Dx: Yes \_\_\_\_ No \_\_\_\_ ICD 10 Code: \_\_\_\_\_\_\_\_\_\_\_\_**

**Planned Procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SHARP REFERRING PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MUST HAVE IF PROVIDER BEING REFERRED TO IS OUT OF NETWORK – REFERRALS ARE FROM SPECIALITY TO SPECIALTY)**

**Admitting/Ordering Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider Tax ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility of Procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Tax ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person completing request form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE PROVIDE CORRESPONDING CLINICALS TO SUPPORT REQUEST**

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| --- |
| **EMAIL COMPLETED FORM TO****precert@sharppho.com****or fax form to 870-972-0036** |

**PLEASE NOTE: NORMAL PRECERTIFICATION TURNAROUND IS 2 BUSINESS DAYS**

**\*\*\*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 SHARP USE ONLY**

**PRECERT # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CASE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE OF SERVICE \_\_\_\_\_\_\_\_\_\_\_**

**REVIEWED BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CASE AGREEMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADMIT DATE \_\_\_\_\_\_\_\_\_\_\_\_\_ REVIEW DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DISCHARGED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**