COMMUNITY HEALTH ALLIANCE

PRECERTIFICATION REQUEST

SUBSCRIBER INFORMATION

ID #: _____ DOB:_____
Name: _____ Telephone:_____
Address:_____Plan Number:_____
Employer of Primary: _____ Group _____

PATIENT INFORMATION

Name:_____DOB:_____
Address: (if different from Subscriber):

SERVICE

OUPATIENT		P.T		O.T.		S.T		DME	
HOMECARE		IMAGING							

INPATIENT		ELOS	

DOCTOR INFORMATION

Name:_____Contact Person:_____
Address:_____
Telephone:_____ Fax:_____
NPI:

PLACE OF SERVICE/HOSPITAL/SURGERY CENTER/PROVIDER'S OFFICE

Facility/Provider Name: _____
Address of Facility:_____
Telephone:_____ Fax: _____
NPI:_____

PROCEDURE INFORMATION

Date of Service/Admission: _____

Diagnosis:_____ **ICD10**_____
Diagnosis:_____ **ICD10**_____
Diagnosis:_____ **ICD10**_____

Procedure:_____ **CPT:**_____
Procedure:_____ **CPT:**_____
Procedure:_____ **CPT:**_____

PLEASE FAX W/ CLINICALS 574-647-1827 or
Email: chaur@beaconhealthsystem.org

UR telephone number: (800) 301-1824 (574) 647-1824
***Please allow 2 business days for a response**
***Authorization does not guarantee payment of benefits**