HealthComp
Third Party Administrators

Precertification Request Form

Date:		Referral Coordinator:		From:	Facility	Provider
Phone:		Ext:		Fax:		
Patient Name:		DOB:		Phone:		
Employee ID #:		Employee Name:				
Address:		City:		State:		ZIP:
Patient has other insurance?	Yes	No	Name of Other Insurance:			
Worker's Comp Related?	Yes	No	If yes, please contact HealthComp directly.	Intake:		
Facility Providing Services:						
(Example: Hospital, DME, Rehab Facility)		TID:				
Address:		City:		State:		
Phone:		Fax:		Zip:		
Services Provided By:						
Physician Name:		Specialty:		TID:		
Address:		City:		State:		
Phone:		Fax:		Zip:		
Requested Services Please provide at least one code in each of the following sections as well as a brief description of services requested.						
ICD-9:						
CPT4/HCPCS:						
Description:						
(DME, Outpatient Services, Elective Inpatient Services)	From:		To:		Days/Visits:	
DME OP IP Other	Purchase Price $:		Rental Price $:			

PLEASE REMEMBER TO INCLUDE ALL CURRENT/RELEVANT CLINICAL DOCUMENTATION.

Please provide photos for any potentially cosmetic procedures.

Upon completion of the form you may submit your precertification request online at www.healthcomp.com by selecting Provider forms, via fax to 559-243-7012 or by clicking here.

For questions please contact HealthComp UM Department at 800-442-7247 option # 3

For HealthComp Use Only					
Group Name:		Group #:		Network:	
Reviewed By:		Review Date:		DOS:	
Requested #:		Approved #:		Precert #:	
Denial Code:		Savings:		Savings Type:	
S E R RE		Comments:			

*Note: Use of non-network providers may result in a reduction of benefits payable by the Health Plan. Please ensure that all providers of service are participating in the Network assigned by your Health Plan, as this is subject to change. The Health Plan sponsored by the above Employer Group has certain provisions requiring medical necessity review. Please be advised that HealthComp's Utilization Management Program cannot deny medical attention. Precertification involves a review of medical necessity only, and does not guarantee payment or confirm coverage. Benefit payments are based on eligibility and the Schedule of Benefits under the Plan at the time of service, and are subject to all Limitations and Exclusions, including limitations and exclusions for Pre-Existing conditions. Please review your Plan Document or contact Customer Service regarding Benefits and Eligibility questions.

Revised 6/12/2013

Thank you for using The HealthComp On-line Precertification Process!

Once we have received all of the necessary information we will be able to provide a timely medical necessity review. Upon completion of the review the referral coordinator will be contacted with the authorization information.

Before completing the on-line precertification form

- ✓ This form must be completed by the provider not the member
- ✓ Please verify HealthComp is the primary UR vendor for this member
- ✓ If this is worker's comp related please contact HealthComp directly
- ✓ Please provide all current/relevant clinical documentation (This will ensure a timely review)

- All required fields are highlighted in Red.
- Remember to attach all current/relevant clinical documentation along with the precertification form.
- Use the drop down arrow for dates
- While printing, click File and Print, then choose Documents and Stamps under the Comments and Forms area. Print page 1 of 2.

Thank you,

HealthComp Utilization Review Team
800-442-7247 option #3