medpartners

Three Rivers Medical Management

Pre-cert Request

FAX to 260-479-3568 **PHONE 888-773-0038 (toll-free) 260-479-3560 (local)**

Request Date _____

Patient Name_____ Date of Birth _____

Address_____ Phone _____

_____

PPO Network_____ **Primary insurance YES**____ **NO**____

Employer_____Group#_____

Subscriber Name_____ ID#_____

Procedure(s)_____ CPT Code_____

_____ CPT Code_____

Diagnosis(s)_____ DX Code_____

_____ DX Code _____

Facility/Service Provider_____ Date of Service_____

Inpatient____ **Outpatient**____ **23Hr Obs**____ **Therapy** ___ **DME**___ **Home Health**____ **Home Infusion**____

Requesting Physician_____

Please call_____ at _____# _____ext_____

Or fax authorization to #_____ (**FAX**)

*******PLEASE ATTACH PERTINENT CLINICAL INFORMATION ON ALL PRECERT REQUESTS**

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TRMM RESPONSE

Authorization # _____ **Approved**_____ **Denied** ____ **Date/time faxed**_____

Approved from _____ **to** _____ **LOS**_____ **Approved by** _____

Criteria used_____ **Service authorized**_____

Authorization Not Needed_____ **by**_____ **date**_____

Please fax clinical information _____ **by**_____ **date**_____

Contact Claim Administrator for Benefits_____

DISCLAIMER: This determination is for medical necessity ONLY and does not verify eligibility and/or benefit coverage. Refer to Claims Administrator or Summary Plan Description.