



# 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.

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