PRE-CERTIFICATION REQUEST FORM

pa group℠ | ACCIDENT & HEALTH

IMPORTANT

Please submit this form and all related correspondence to: PA Group Administration. See contact details at the bottom of the page.

GUIDELINES

Pre-Certification is the process of confirming eligibility and benefits prior to a service, which may require pre-approval in accordance with the conditions of the policy. Pre-certification does not guarantee payment. It is the member's responsibility to familiarize themselves with the terms and conditions of their policy. Make sure information is legible and completed to its entirety. Please attach relevant Clinical Documentation to this request.

PATIENT INFORMATION (REQUIRED)

1. Insured Name (Last, First, MI): _____

2. Patient Name (Last, First, MI): _____

3. Member ID / Policy #: _____ 4. Date of Birth (MM/DD/YYYY): _____

5. Address: _____ 6. City: _____

7. State/Province: _____ 8. Postal Code: _____ 9. Country: _____

10. Effective Date of Policy (MM/DD/YYYY): _____ 11. End Date of Policy (MM/DD/YYYY): _____

12. Policy Limitations / Exclusions: _____ 13. Co-Insurance Percentage: _____

14. Deductible: _____ 15. Gender: ☐ MALE ☐ FEMALE

PRE-CERTIFICATION

16. Facility Name: _____ 17. Facility Contact Person: _____

18. Telephone Number: _____ 19. Fax Number: _____

20. Address: _____ 21. City: _____

22. State/Province: _____ 23. Postal Code: _____ 24. Country: _____

25. Admitting Physician: _____ 26. Physician Address: _____

27. City: _____ 28. State/Province: _____ 29. Postal Code: _____ 30. Country: _____

31. Telephone Number: _____ 32. Fax Number: _____

33. Admission Date: _____ 34. Estimated Length of Stay: _____

35. Number of days Requested: _____ 36. Surgical Admission? ☐ YES ☐ NO

37. Diagnosis of Chief Complaint: _____ 38. Treatment Requested: _____

39. ICD Code(s): _____ 40. CPT Code(s): _____

41. Type of Treament (Select one) ☐ Inpatient ☐ Emergency ☐ Outpatient ☐ Diagnostic (Labs, MRI, X-ray) ☐ Other

SIGNATURE & DATE

SIGNATURE

DATE (MM/DD/YYYY)

IMPORTANT NOTICE: Upon receipt of this information We will have our medical team evaluate all pertinent information and make a determination based on medical necessity. We will at all times attempt to settle the costs directly with the hospital however; it is in the hospital and/ or provider's discretion to accept. In the event that the hospital does not accept a direct settlement, the member will need to settle the invoice in full and submit for reimbursement in accordance with the cost previously informed to the member that was considered as reasonable and customary.

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