

**INPATIENT MEDICAL AND MENTAL HEALTH
PRECERTIFICATION / PRIOR AUTHORIZATION
CONCURRENT REVIEW FORM**



Completion of this fax will serve as notice to PreferredOne of an episode of care. In addition to demographic information, clinical documentation (including H&P) must be provided to perform the medical necessity review and final completion of the certification process. Concurrent review requests require the following as applicable: attending healthcare provider progress notes, consult notes, vital signs, medications, lab and test results, additional surgical procedures, therapy notes (including therapy goals and activity level), plan of care, and discharge planning.

Please email this form and clinical documentation to Intake@Preferredone.com or fax to (763) 847-4014.

Check reason for Initial Inpatient Precertification / Prior Authorization Request:			
<input type="checkbox"/> MED <input type="checkbox"/> SURG <input type="checkbox"/> MH <input type="checkbox"/> Detox <input type="checkbox"/> RTC-CD <input type="checkbox"/> RTC-MH			
MEMBER / SUBSCRIBER INFORMATION			
Patient Name		PreferredOne ID #	DOB
Address			
City		State	Zip Code
Phone	Email Address		

ADMITTING / TREATING PHYSICIAN / PROVIDER			
Requester Contact Name		Phone	
Fax	Email		
Ordering Provider Name (First & Last)		NPI #	
Clinic Name		NPI #	
Address			
City		State	Zip Code
Phone		Fax	
Servicing Hospital Name		NPI #	
Address			
City		State	Zip Code
Phone		Fax	Admit Date

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Patient Name
PreferredOne ID #

Utilization Review Contact Name	Phone	Fax
Discharge Planner Contact Name	Phone	Fax
Diagnosis Code(s)		
Surgical or Medical Procedure Code(S)		
Acute symptoms/history/pertinent tests and results		
Current TX plan		