PreferredOne Precertification/ Prior-Authorization Concurrent Review Fax
Phone: 763-847-4477/800-997-1750
Fax: 763-847-4014

Completion of this fax will serve as notice to PreferredOne of an episode of care. In addition to the demographics, clinical information must be provided by fax to perform the medical/therapeutic necessity review and final completion of the certification process. WHEN FILLING OUT THIS FORM PLEASE PRINT OR TYPE.

Check reason: MED____ SURG____ MH____ CD____ INPT____ OUTPT____ ER____ ELEC____ URG___

Contact Person_____ Phone_____ Fax_____

Patients Name_____ ID #_____ DOB_____

Male ρ Female ρ Address_____ City_____

State_____Zip code_____ phone #_____

Subscriber's Name_____ ID #_____

Subscriber's Employer Name_____

Subscriber's Relationship to Patient_____ Account #_____

Admitting/Treating Physician/Provider

Providers Name_____ NPI #_____

Clinic Name_____NPI#_____

Address_____

City_____State_____ Zip code_____ Phone_____

Fax_____

Hospital Name_____

Address_____ City_____

State_____ Zip code_____ Phone_____

Admit Date _____ Diagnosis Code(s) _____ _____

Surgical or Medical Procedure code(s)_____ _____

Acute symptoms/history/pertinent tests and results_____

_____

_____

_____

_____

Current TX plan_____

_____

_____

_____

Subsequent review should include vital signs, medications, current lab and test results, additional surgical procedures, activity level and rehab. PLEASE NOTE: INCOMPLETED FORMS WILL BE RETURNED

UPDATED: 2/10/2015