DOCTORS DIRECT HEALTHCARE

Pre-Certification Form – Must Be Complete and requires 48 hours to process

Retroactive Request requires 15 days to process

Patient Name (required)		Insurance ID# (required)	Group # (required)	Date of Birth (required)
Admitting/Ordering MD (name) Tax ID #	Check one: Network IN ☐ OUT ☐	Phone #	Fax #	Contact Ext:
Facility/Provider of Service (name) Tax ID #	Check one: Network IN ☐ OUT ☐	Phone #	Fax #	Contact Ext:
Diagnosis Codes	Diagnosis			
CPT or Supply Codes	Procedure/Surgery/DME/Admission: services that you are providing			

Date of Admission or Start Date of Service ☐ Inpatient ☐ Outpatient / 24 hour observation	Date of Discharge or End Date of Service
Document Supporting Clinical Below or Include Clinical Office Notes to Support Your Request Total number of pages faxed: ☐	

For Doctors Direct Healthcare Use Only:

Date Rec'd_____________________ Criteria____

DDHC Approved: Y N DATE:____________________

Date Letter/Fax Sent: _____________________________Representative Signature:___________________________

NOTE:

- THIS AUTHORIZATION DOES NOT GUARANTEE PAYMENT.
- PAYMENT IS SUBJECT TO MEMBER ELIGIBILITY, NETWORK AND COVERAGE AT THE TIME OF SERVICE.
- IF YOU WISH TO APPEAL THIS DECISION, CHANGE THE DATE OF SURGERY, OR CHANGE THE PLANNED SURGICAL PROCEDURE PLEASE CONTACT US AT THE PHONE NUMBER BELOW.
- **IF YOU DO NOT RECEIVE RESPONSE WITHIN 2 BUSINESS DAYS PLEASE CONTACT US AT THE NUMBER BELOW**

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