PINNACLE™
HEALTH MANAGEMENT

UTILIZATION MANAGEMENT AUTHORIZATION FORM

ROUTINE ☐ **URGENT** ☐ **48 HOURS** ☐ **STAT** ☐

PLEASE SUBMIT THIS COMPLETED PRE-CERTIFICATION REQUEST WITH CLINICAL NOTES

Patient Name:	ID #:
Date of Birth:	Patient Telephone #:

SERVICE REQUESTED:

Inpatient ☐ Outpatient Surgery ☐ Medication ☐ DME ☐ PT ☐ OT ☐ Speech Therapy ☐
Home Health Care ☐ Infusion Therapy ☐ Chemotherapy ☐ Skilled Nursing Facility ☐ MRI ☐
CT Scan ☐ Behavioral Health ☐ Other ☐ _____

DATE OF SERVICE: _____ **# OF TREATMENTS REQUESTED:** _____

DIAGNOSIS AND SERVICE CODES:

ICD10 Code/ Diagnosis:	CPT Codes:
HCPC Codes:	J Codes:

REFER-TO-PROVIDER INFORMATION – HOSPITAL/FACILITY/ PROVIDER OF SERVICE:

First Name:	Last Name:
Tax ID#:	Telephone #:
Fax #:	Address:
Address, cont.:	

ORDERING PROVIDER:

First Name:	Last Name:
Tax ID#:	Telephone #:
Fax #:	Address:
Address, cont.:	

CONTACT PERSON:

First Name:	Last Name:
Telephone #:	Fax #:
Comments:	

Approval does not guarantee that any or all benefits will be paid. The Claims Department will determine whether benefits are payable when the documentation is received. Payment of benefits will be based on Usual and Customary and is subject to all terms and requirements of the Plan. Please refer to the Summary Plan Description for details about Plan Benefits such as Limitations, Exclusions, Waivers, Pre-existing Conditions, Usual and Customary fees, etc.. Routine requests will be completed within five (5) working days of receipt.