Covenant MSO
EMPLOYEE BENEFIT PLAN

Referral Type
□ Routine (Process in 48 hours)
□ Urgent (Process in 24 hours)

MediView Utilization Management
Surgical Precertification Form

DATE: _____

PATIENT NAME: _____ DOB: _____

PRIMARY INSURANCE: _____ SUBSCRIBER ID: _____

SECONDARY INSURANCE: _____ SUBSCRIBER ID: _____

WORK RELATED □ YES □ NO **AUTO ACCIDENT** □ YES □ NO **POSSIBLE COB** □ YES □ NO
IF YES, PLEASE EXPLAIN: _____

_____

REQUESTED BY (PHYSICIAN): _____

CONTACT PERSON AT PHYSICIAN'S OFFICE: _____

PHONE #: _____FAX #: _____

PRIMARY CARE PHYSICIAN: _____

PLACE OF SERVICE: _____ DATE OF SERVICE: _____

SURGEON: _____ SPECIALTY: _____

ASSISTANT SURGEON: □ NO □ YES – NAME: _____ SPECIALTY: _____

PLEASE CHECK ONE: □ OUTPATIENT □ 23 HOUR OBSERVATION □ INPATIENT (EST. LOS _____)

DIAGNOSIS: _____ ICD-10 CODE(S): _____

CURRENT PRODEDURE CODE(S): _____

PERTINENT CLINICAL INFORMATION, INCLUDING DIAGNOSTIC RESULTS: _____

_____

_____

Please fax clinicals along with this form.

UM PHONE #: (512) 806-0162 or (855) 397-3215 UM FAX #: (877) 300-3764 or (877) 938-2079