

**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.**

THIS AUTHORIZATION IS NOT A GUARANTEE THAT SERVICES WILL BE COVERED OR THAT PAYMENT WILL BE MADE. ALL MEDICAL SERVICES RENDERED ARE SUBJECT TO CLAIMS REVIEW, WHICH INCLUDES BUT IS NOT LIMITED TO DETERMINATION OF ELIGIBILITY IN ACCORDANCE WITH THE TERMS OF THE MEMBERS BENEFIT PLAN, ANY DEDUCTIBLES, CO-PAYMENTS AND CUSTOMARY CHARGES AND POLICY MAXIMUMS.

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