ConnectCare PRECERTIFICATION FORM **DATE** _____

EMPLOYEE NAME _____

PATIENT NAME _____ **PATIENT DOB** _____

COVERAGE INFORMATION

PLEASE CIRCLE MEMBER'S GROUP

POLICY NUMBER _____ MyMichigan Health

GROUP NUMBER _____ Northwood University

PHYSICIAN NAME: _____

☐ INPATIENT ADMISSION ☐ OUTPATIENT PROCEDURE OR SURGERY

☐ DME (Attach prescription)

DATE OF ADMISSION/SURGERY/PROCEDURE _____

Inpatient admissions and certain outpatient procedures may require preauthorization prior to approval

FACILITY NAME _____

PLACE OF SERVICE: ☐ PROVIDER OFFICE ☐ HOSPITAL ☐ OTHER
If not INPATIENT

REASON FOR SERVICE: ICD-10 DIAGNOSIS CODE(S) _____ _____

PROCEDURE/CPT 4 CODE(S) _____ _____

DIAGNOSIS _____

Person Making Request _____ **Telephone** _____

Office or Facility _____ **FAX Number** _____

Precertification Number _____ Duration _____

Comments _____

_____

_____

Representative _____ Date Received _____

Precertification telephone number in Midland (989) 839-1629 option 3 or toll-free (888) 646-2429 or FAX (989) 839-1679