

Request Date: _____

Benefit Certification Request Form

Outpatient and Clinical Information Fax: (505) 213-0246 Inpatient Fax: (505) 213-0181

Routine

Urgent or Expedited Initial Determination

**For a Benefit Certification request to be considered "Urgent" or "Expedited," check all that apply.
Please note: Requests that do not meet this criteria may be processed as routine requests.**

The life or health of a covered person would be jeopardized

The covered person's ability to regain maximum function would be jeopardized

The medical exigencies of the case require an expedited decision

Practitioner Signature: _____ (Required for Urgent or Expedited requests.)

Complete the information below and attach all of the clinical information pertinent to the request.

Member Name: _____ ID Number: _____ DOB: _____

Requesting Provider: _____ Phone: _____ Fax: _____

Contact Person: _____ Phone: _____ Fax: _____

Servicing Provider/Facility: _____ Phone: _____ Fax: _____

Services Requested

New/Initial Request Ongoing Care Previous Certification Number: _____

DME/Prosthetic/Orthotic Ambulatory/Outpatient Surgery SNF PET Scan

Out-of-Plan Services Other: _____

Inpatient LOS: _____ Facility: _____

Prescription Attached Clinical Information Attached

Requested Effective Date: _____ End Date: _____ Number of Services: _____

Diagnosis (ICD-9): _____ _____ _____ _____

Procedure (CPT/HCPC): _____ _____ _____ _____

Symptoms and Summary of Previous Treatment: _____

