CareAllies Initial Pre-Certification Request Form

Please provide the following information for review of services.

Fax request to 866-535-8972 and the review will be initiated.

- If clinical information is available, attach with this form.

Employer/Fund Information:

Employer/Fund Name:

Member/Patient Information:

Member/Patient Name:

Street Address:

City:

DOB:

ID:

State:

ZipCode:

Phone#:

Servicing Health Care Professional Information:

Provider Name:

Phone#:

Fax #

Street Address:

City:

State:

ZipCode:

Facility Information:

Facility Name:

Phone#:

Fax #

Street Address:

City:

State:

ZipCode:

Review Request Detail Information:

ICD-9 Code/s:		CPT Code/s:	
Level of Care:		Date of Service:	

Further Guideline Information:

For Further guideline information, please visit us at:
http://www.careallies.com/healthcare_professionals.html