

**Saint Mary's Preferred HealthCare Network**

1625 E. Prater Way, Bldg. C., Suite 101

Sparks, NV. 89434

(775) 352-6939 OR 800-455-4236 x6939

**FAX: (775) 352-6992**

**PRE CERTIFICATION REQUEST FORM**

**\*\*\*ALL AREAS MUST BE COMPLETED\*\*\***

**THIS FORM IS TO BE COMPLETED IN FULL BY THE ATTENDING PHYSICIAN WHO WILL BE REQUESTING CERTIFICATION OF SERVICES. \*BE SURE THAT THIS FORM IS FILLED OUT COMPLETELY. RETURN THIS FORM IMMEDIATELY TO PREFERRED HEALTHCARE NETWORK AT THE ADDRESS LISTED ABOVE, OR BY FAX. IF PREFERRED HEALTHCARE NETWORK DOES NOT RECEIVE THIS FORM WITHIN SEVEN (7) BUSINESS DAYS PRIOR TO SERVICE, A REDUCED BENEFIT MAY BE APPLICABLE ACCORDING TO YOUR BENEFIT PLAN.**

EMPLOYEE'S SOC. SEC. NO.	EMPLOYEE'S NAME	NAME OF EMPLOYER
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PATIENT NAME: LAST	FIRST	MI
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INSURED PHONE #	PATIENT DOB MO DAY YR	SEX M F <input type="checkbox"/> <input type="checkbox"/>	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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EMPLOYEE MAILING ADDRESS	City	State	Zip
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IS YOUR SPOUSE EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	SPOUSE'S FIRST NAME	SPOUSE'S SOC. SEC. NO.	Group No/ ID #
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IS PATIENT COVERED BY ANOTHER PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF INSURANCE COMPANY
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**\*INCLUDE ALL APPROPRIATE CLINICAL, LAB, AND X-RAYS THAT SUPPORT THIS REQUEST.**

MEDICAL CONDITION (DIAGNOSIS):	ICD9-CM NUMBER	FACILITY NAME/PHONE/FAX
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SERVICE PLANNED 1.	CPT NUMBER	PLANNED DATE OF SERVICE <b>(REQUIRED, EVEN IF TENTATIVE)</b>
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2.	<b>STATUS: *Please check all that apply</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Diagnostic <input type="checkbox"/> In Office Procedure <input type="checkbox"/> Outpatient <input type="checkbox"/> Same Day Surgery	
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Physician Name, Address, Zip Code	<b>CONTACT:</b> Name: _____ Phone: _____ FAX: _____
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<b>FOR PHCN USE ONLY</b>	<b>VARIANCE DATA</b>
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Date	OMP	App Y/N	I/O	Comments:
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Pre-Certification #:
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