



Precertification Request Form



*****Please totally complete each line or the form will be returned before processing*****

Patient Name: _____ Insurance ID# _____ DOB: _____

Patient Address: _____ Patient Phone# _____

Insured Name: _____ Employer: _____

DOS/Admission: _____ Please check: Inpatient _____ Outpatient _____

Provisional Diagnosis: _____ High Risk Dx: Circle Yes No ICD10: _____

Planned Procedure: _____ CPT(s): _____

Referring Physician _____ *****Precertification number will not be issued without this*****

Admitting Physician/Ordering Provider: _____ Provider Phone: _____

Provider Email: _____ Provider Tax ID #: _____

Facility of Procedure: _____ Facility Contact Name: _____

Facility Contact Phone: _____ Fac Tax ID #: _____

Please provide corresponding clinicals to support this request.

Please note: Normal precertification turnaround – 2 business days

**EMAIL COMPLETED FORM TO
precert@sharppho.com**

******This precertification does not guarantee that the service requested is a covered benefit, nor does it guarantee payment of claims. For eligibility, please contact the third party administrator.******

For Office Use Only – Case #: _____ Precert #: _____

Reviewed: _____ Date: _____

TR: _____ Discharged: _____ TPA Notified: _____

Case Agreement: _____ Referral: _____