Pre-Certification Form

Date: ______________

To prevent delays in processing your request, please fill out the form in its entirety and submit all appropriate clinical information and any other required documents to support your request. If this is a request for an extension or modification of an existing authorization from HealthSun Health Plans, Inc., please provide the authorization number with your submission.

To ask a question or submit your precertification request, please use the following contact information:

Phone: 1-877-207-4900 ● Fax: 305-448-4148 ● E-mail: utilization_dept@healthsun.com

Member Information	
Name:	Member ID:
Phone:	DOB:
Address (Street, City, State, Zip code):	
PCP / Referring Provider ☐ Participating ☐ Nonparticipating	
Name:	Specialty:
NPI / Provider ID:	Office contact name:
Provider's Address (Street, City, State, Zip):	
Office phone:	Office fax:
Supporting documentation included with the referral: ☐ Yes ☐ No	
Referred to Provider / Facility: ☐ Participating ☐ Nonparticipating	
Specialist Name:	Facility Name:
NPI / Provider ID:	NPI / Facility ID:
Provider's Address (Street, City, State, Zip):	Facility's Address (Street, City, State, Zip):
Office Contact Name:	Facility Contact Name::
Phone #:	Phone #:
Fax #:	Fax #:

Service(s) Requested	
Date of Service:	Diagnosis/Complaint:
Specific Procedure (s):	
ICD-10 Code (s):	ICD-10 Description:
CPT Code (s):	# Visits requested:

Type of service (check all that apply):

☐ Outpatient Services ☐ Inpatient Surgical ☐ Pharmacy (Part B Drugs)
☐ Home health ☐ Durable medical equipment ☐ Diagnostic study ☐ Office visit
☐ Other (please specify): ____

Place of Service

☐ Hospital	☐ Ambulatory surgery center	☐ Office
☐ Independent lab	☐ Diagnostic facility	☐ Other: ______________

Additional information

☐ Expedited/STAT: Use for **inpatient/outpatient** services only when provider indicates that the need for services is urgent or expedited.

☐ Standard Request: Non-urgent/Expedited service.

Physician Signature: ____

NOTE: Please contact HealthSun Health Plans, Inc. for additional services not listed above. This certifies that the service requested is eligible for reimbursement only with the CPT Code listed subject to CMS verification of the Members eligibility with HealthSun on the date of service.

Submit All Claims With This Form To:
HealthSun Health Plans, Inc. Attn: Claims Department **P.O. BOX 211154** **EAGAN, MN 55121**

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