Inpatient and Outpatient Precertification Form

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VIVA HEALTH USE ONLY
☐ Medicare ☐ Commercial

TO BE COMPLETED BY ADMITTING PHYSICIAN:

Patient Name: _____ Date of Birth: _____ Other Insurance: _____

Member Number: _____ Group Number: _____

Person Completing Form: _____ Phone: _____ Fax: _____

Admitting MD: _____ Facility Name: _____

MD NPI: _____ Facility Tax ID: _____

Diagnosis:	ICD-10 Code:	Procedures:	CPT:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Admit Date or Procedure Date: _____ Requested Length of Stay: _____

Prior Level of Function: _____
Current Level of Function: _____
Past Medical History: _____
_____

Summary of Previous Outpatient Treatment (attach clinical info and number of pages): _____
_____
_____

Medical Indication for Requested Service: _____
_____
_____

Treatment Plan: _____
_____
_____

FOR DELIVERY ADMIT EDC: _____ Expected Type of Delivery: _____

This approval does not authorize services not covered by the benefits currently provided under the member's benefit plan. For the services to be covered, the member must be enrolled and effective at the time the service is provided.