

SmartHealth Member ID: _____

Please indicate: Start of treatment: Start Date ____/____/____
 Continuation of treatment: Date of Last Treatment ____/____/____

Precertification Requested by: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:		State: ZIP:
SmartHealth ID:			Phone:		Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms				Allergies:	

B. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): M.D. D.O. N.P. P.A.	
Address:			City:		State: ZIP:
Phone:			Fax:		
NPI #:			Tax ID:		
Contact Name:		Contact Email:		Contact Phone:	

C. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ Administration Code(s) (CPT): _____ Address: _____		Place of Dispensing (Provider/Pharmacy): <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Hospital Based Medication <input type="checkbox"/> Clinic Medication <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ NPI: _____	
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D. DIAGNOSIS INFORMATION

Diagnosis:	Staging:	ICD-10:
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E. CLINICAL INFORMATION – Provide medical necessity documentation for the requested medication including other medications tried (attach supporting documentation).

Clinical documentation to support medical necessity should be faxed back along with the completed form.

F. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ Date: ____/____/____

Precertification does not guarantee payment for services. Eligibility for and payment of services are subject to all terms, conditions and limitations of the Plan at the time the services are rendered.

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G. MEDICATION(S)/ONCOLOGY OR COMPLEX REGIMEN

1 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): <i>(if available)</i>	
2 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): <i>(if available)</i>	
3 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): <i>(if available)</i>	
4 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): <i>(if available)</i>	
5 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): <i>(if available)</i>	
6 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): <i>(if available)</i>	
7 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): <i>(if available)</i>	

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G. MEDICATION(S)/ONCOLOGY OR COMPLEX REGIMEN CONTINUED

8 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): (if available)	
9 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): (if available)	
10 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): (if available)	
11 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): (if available)	
12 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): (if available)	
13 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): (if available)	
14 Medication Name/Strength:		Dosing per Administration:	
Route of Administration:	Quantity:	Day Supply:	Expected Duration of Therapy:
HCPCs Code:		National Drug Code (NDC): (if available)	