

SmartHealth ID: _____ Please indicate: Start of treatment: _____
Continuation of treatment: _____ Date of Last Treatment: _____
Precertification Requested by: _____ Phone: _____ Fax: _____

A. Patient Information

First Name:		Last Name:		DOB:	SmartHealth ID:
Address:			City:	State:	ZIP: Phone:
Email:	Patient Current Weight: lbs or kgs	Patient Current Height: in 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: Self-Administered Physician's Office Outpatient Infusion Center Phone: _____ Center Name: _____ Home Infusion Center Phone: _____ Agency Name: _____ Administration Code(s) (CPT): _____ Address: _____		Place of Dispensing (Provider/Pharmacy): Physician's Office Retail Pharmacy Hospital Based Medication Clinic Medication Specialty Pharmacy Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ NPI: _____	
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D. Diagnosis Information

Diagnosis:	Staging:	ICD Code:
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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.

SmartHealth ID: _____

Please indicate:

Start of treatment: _____

Start Date ____/____/____

Continuation of treatment: _____

Date of Last Treatment ____/____/____

Precertification Requested by: _____

Phone: _____

Fax: _____

G. Medication(s)/Oncology or Complex Regimen

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