SmartHealth

# Medical Specialty Precertification Report

SmartHealth Precertification
Phone: 833-594-1845
Fax: 833-594-1875

SmartHealth 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: | 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: ______________

## D. Medical Information

| Medication Name/Strength: | Dosing per Administration: | Day Supply: | Expected Duration of Therapy: |
|---|---|---|---|
| Route of Administration: | Quantity: | HCPCs Code: | National Drug Code (NDC): *(if available)* |

## E. Diagnosis Information

| Diagnosis: | Staging: | ICD Code: |
|---|---|---|

## F. 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.*

## G. 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.**

Ascension