

NEIGHBORHOOD HEALTH PARTNERSHIP

AFTER HOURS HOSPITAL PRE-CERTIFICATION FORM

Please fax form to: 800-731-2430

- Please be advised, failure to comply with Utilization Management certification protocol will result in non-payment of your claim.
- Failure to provide clinical information at the time of faxed notification may delay the authorization process.
- Verification of benefits, eligibility, or authorization of a service is not a guarantee of payment. Payment remains subject to all of the terms and conditions of the member's benefit plan, including exclusions and limitations. If this member's coverage has a pre-existing condition exclusion, payment will be subject to a pre-existing condition investigation at the time claims are filed.

Patient Information		Requesting Hospital Information	
Patient Name: _____		Hospital Name: _____	
ID Number: _____		Phone: _____	
Patient DOB: ____/____/____		Fax #: _____	
Admit Date: _____		Contact Name: _____	
Room #: _____		# of pages of accompanying clinical information: _____	
Admit Type (ER or Direct):			
Admitting Physician:			
Admitting Diagnosis			
Floor Type (ICU, Telemetry etc.)			
Pertinent Clinical Information			