Horizon Blue Cross Blue Shield of New Jersey

# Fax Medical Necessity Determination Request Cover Sheet

Please attach all relevant medical records that support this request.

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

| | Fax No. |
|---|---|
| Diagnosis of Obstructive Sleep Apnea | 1-888-608-1015 |

**Patient/Subscriber Information:**

Patient Name: _____ (Last) _____ (First) _____ (MI) ID#: _____

DOB: _____ (MM) / _____ (DD) / _____ (YYYY) Gender: ☐ M ☐ F

Subscriber Name: _____ (Last) _____ (First) _____ (MI)

Relationship to patient: ☐ Self ☐ Spouse ☐ Child Is there any other Insurance? ☐ Yes ☐ No If so, name of other insurance carrier: _____

**Physician Information:**

Ordering Physician: _____ ☐ PCP or ☐ Specialist NPI/TIN#: _____

Contact Person: _____ Phone #: _____ – _____ – _____ Ext: _____ Fax #: _____ – _____ – _____

Office Location: _____ Was patient referred by PCP? ☐ Yes ☐ No If the physician in non par, is the member aware? ☐ Yes ☐ No

**Service That Medical Necessity Determination Is Being Requested:**

Provider Services 1-800-624-1110 should be contacted to verify member eligibility.

Procedure: _____ CPT4: _____ DX/ICD-10: _____ DX/ICD-10: _____

Anticipated Date of Service: _____ (MM) / _____ (DD) / _____ (YYYY) Facility/Location: _____

**STAT requests can only be made by the ordering physician, where the physician indicates (and supplies supporting documentation) that applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**
**Any request for retrospective Medical Necessity Determination will not be considered on a STAT basis.**

Additional information pertinent to this Request: _____

_____

**Medical Necessity Determination Status:**

Approved: _____ Reference #: _____ *Expiration Date: _____ (MM) / _____ (DD) / _____ (YYYY) Date Medical Necessity Determination completed: _____ (MM) / _____ (DD) / _____ (YYYY)

Denied: _____ Reason: _____ By: _____ Ext: _____

Pended: _____ For additional medical information ☐ For medical Review ☐ Information By: _____ Date: _____ (MM) / _____ (DD) / _____ (YYYY)

Comments: _____

*** This determines the medical necessity of the services requested based upon the information provided. It is NOT a guarantee of payment. It is issued subject to the terms and limitations of your agreement and the member's benefit plan, and subject to the member being eligible at the time services are provided. We reserve the right to deny reimbursement in the event of fraud or misrepresentation or if there is a material change in facts and circumstances that varies from the information that was provided with the original request.**



31245 (0915)

PLEASE ENSURE ALL PERTINENT CLINICAL INFORMATION IS ATTACHED.