

CareAllies Initial Pre-Certification Request Form

Please provide the following information for review of services.

Fax request to 866-623-5793 and the review will be initiated.

- If clinical information is available, attach with this form.

Employer/Fund Information:

Employer/Fund Name:	<input type="text"/>
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Member/Patient Information:

Member/Patient Name:	<input type="text"/>	DOB:	<input type="text"/>
Street Address:	<input type="text"/>	ID:	<input type="text"/>
City:	<input type="text"/>	State:	<input type="text"/>
		ZipCode:	<input type="text"/>
		Phone#:	<input type="text"/>

Servicing Health Care Professional Information:

Provider Name:	<input type="text"/>	Street Address:	<input type="text"/>
Phone#:	<input type="text"/>	City:	<input type="text"/>
Fax #		State:	<input type="text"/>
		ZipCode:	<input type="text"/>

Facility Information:

Facility Name:	<input type="text"/>	Street Address:	<input type="text"/>
Phone#:	<input type="text"/>	City:	<input type="text"/>
Fax #		State:	<input type="text"/>
		ZipCode:	<input type="text"/>

Review Request Detail Information:

ICD-9 Code/s:	<input type="text"/>	CPT Code/s:	<input type="text"/>
Level of Care:	<input type="text"/>	Date of Service:	<input type="text"/>

Further Guideline Information:

For Further guideline information, please visit us at:

http://www.careallies.com/healthcare_professionals.html

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