Kern Legacy Classic or Max Plan - Precertification Request Form

All **BOLD** fields are **REQUIRED**

Standard (you will receive a determination within 5 days)

Urgent (you will receive a determination within 3 days)

Emergency (you will receive a determination within 24 hours)

Patient Information

Last Name:	**First Name:**	**Suffix:** (if applicable)	M/I:
Patient Insurance ID:	**Subscriber Insurance ID:**	**Relationship:**	
Address:	City:		
State: / Zip: / Phone:	**Birth Date:** / Age: / **Sex:**		

Subscriber Information

Last Name:	**First Name:**	**Suffix:** (if applicable)	M/I:

Provider Information

Requesting Physician:	**NPI:**	**Tax ID:**
Address:	**Phone:**	**Fax:**

Precertification Details (required for all precertifications)

Type of Service: Inpatient Outpatient Observation		**Date of Service:**	
Facility Name:	**NPI:**	**Tax ID:**	
Address:	**City:**	**State:**	**Zip:**

Reason for Request (include any symptoms and test information)

Include any related documentation with this form

Diagnosis Codes (ICD-10) (at least ONE diagnosis code is required for ALL requests)

	Code	Description		Code	Description
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Treatment Codes (CPT) (at least ONE code required for ALL PRECERTIFICATIONS)

	Code	Description	Units
1.			
2.			
3.			
4.			
5.			

CLINIX HEALTHCARE

For the Administration of the
County of Kern Point of Service
Employee Health Plan

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