

**MDwise Saint Margaret Mercy Healthcare Delivery System  
Precertification Form**

Phone: 800-291-4140

Fax: 800-747-3693

***PMPs do not require precertification for procedures performed in office***

**Please Print. Please fill out form as completely as possible to avoid delays in processing**

Date: \_\_\_\_\_

Person submitting request: \_\_\_\_\_ Phone # \_\_\_\_\_

Patient Name: \_\_\_\_\_ ID # \_\_\_\_\_

DOB: \_\_\_\_\_

PCP: \_\_\_\_\_ Fax # \_\_\_\_\_

Referring to: \_\_\_\_\_ Specialty \_\_\_\_\_

Ph # \_\_\_\_\_ Fax # \_\_\_\_\_

Date of Service: \_\_\_\_\_ Diagnosis (ICD-9) \_\_\_\_\_ CPT/HCPCS \_\_\_\_\_

Type of Service:

Office visit \_\_\_\_\_ Inpatient \_\_\_\_\_ Outpatient \_\_\_\_\_ DME \_\_\_\_\_

Place of Service: \_\_\_\_\_

Referred by PMP: \_\_\_\_\_ Self Referred: \_\_\_\_\_

Pertinent Medical Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is injury result of motor vehicle accident or work related? Yes \_\_\_\_\_ No \_\_\_\_\_

Additional insurance: \_\_\_\_\_

**(Please send copy of other insurance card)**

Auth # \_\_\_\_\_ Dates \_\_\_\_\_ # Visits \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_