



**Utilization Management**  
**Phone: 1-877-284-0102      Fax: 1-800-510-2162**

**Nasal Septoplasty Precertification Review**

Date: \_\_\_\_\_ Reference #: \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call Healthlink at 1-877-284-0102.*

**Hospital Information**

Hospital Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
 ID Number: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Physician Information**

Ordering Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 TIN: \_\_\_\_\_

**Treatment Information**

Is patient being treated?     Outpatient     Inpatient  
 Admission Date: \_\_\_\_\_  
 Anticipated length of stay: \_\_\_\_\_  
 Diagnosis (ICD-9) Code: \_\_\_\_\_  
 Surgery (HCPC/CPT) Code: \_\_\_\_\_  
 Date of Surgery: \_\_\_\_\_  
 Is this procedure related to an accident?     YES     NO  
 If **yes**, please indicate date, type and site: \_\_\_\_\_

Pertinent History/ Signs/Symptoms (submit history, physical and/or hospital discharge summary with this form): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please check all of the following that apply:  
 Is there a Septal deviation?     YES     NO

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

