



**Utilization Management**  
**Phone No.: 1-877-284-0102      Fax No.: 1-800-510-2162**

**Request for Rhinoplasty Precertification Review**

Date: \_\_\_\_\_ Notification # \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification 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 No. \_\_\_\_\_ Fax: (Required) \_\_\_\_\_

**Patient's Information**

Patient's Name: \_\_\_\_\_  
ID Number \_\_\_\_\_ Patient's DOB: \_\_\_\_\_  
Address \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Daytime Phone No. \_\_\_\_\_

**Physician's Information**

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

**Treatment Information**

Outpatient     Inpatient  
Admission Date: \_\_\_\_\_ Anticipated length of stay: \_\_\_\_\_  
Admitting DX/ICD-9 Code: \_\_\_\_\_  
Surgery CPT Code: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

If related to an accident, please indicate date, type and site: \_\_\_\_\_  
\_\_\_\_\_

Related HX/Current Signs/Symptoms: \_\_\_\_\_  
\_\_\_\_\_

Is there documentation of failure of conservative medical therapy for severe airway obstruction from deformities due to disease, structural abnormality, or previous therapeutic process that will not respond to septoplasty alone  
 YES     NO

If YES, What conservative medical therapy was used and when \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AND**

Will the procedure be reasonably expected to improve the physical functional impairment     YES     NO

**Plan of Treatment:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Comments:**

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**Contact Information**

Contact Person \_\_\_\_\_  
Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Staff Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

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.