



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

Request for Septoplasty 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:

Please check all of the following that apply:

- Septal deviation YES NO
If yes, what percentage (%) is the septum deviated
Is the septum deviated to the left or right Left Right
Persistent or recurrent epistaxis YES NO
Chronic, recurrent sinusitis YES NO
Distressing symptoms of nasal obstruction with documented absence of other causes of obstruction likely to be responsible for the symptoms (e.g., nasal polyps, tumor, turbinate hypertrophy, etc.) YES NO
Asymptomatic deformity that prevents surgical access to other intranasal or paranasal areas (e.g., sinuses, turbinates) YES NO
Has a trial of conservative management (e.g., topical nasal corticosteroids, decongestants, antibiotics, allergy evaluation and therapy, etc.) been used YES NO

If yes, please specify all conservative management used, and length of trial:

Plan of Treatment: _____

Additional Comments:

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.