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-10) 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: ____

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

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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.

If yes, what percentage (%) is the septum deviated? _______________

If yes, is the septum deviated to the left or right? ☐ Left ☐ Right

Is there persistent or recurrent epistaxis? ☐ YES ☐ NO

Is there chronic, recurrent sinusitis? ☐ YES ☐ NO

Are there 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

Is there asymptomatic deformity that prevents surgical access to other intranasal or paranasal areas? (e.g., sinuses, turbinates) ☐ YES ☐ NO

Has a trial of conservative management been used? (e.g., topical nasal corticosteroids, decongestants, antibiotics, allergy evaluation and therapy, etc.) ☐ YES ☐ NO

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

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Plan of Treatment: ____

Additional Comments

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Contact Information

Contact Person: ____

Title: ________________________________

Phone: ________________________________

Fax: ________________________________

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