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

Rhinoplasty 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: _____

Address: _____

Patient DOB: _____

Phone: _____

Physician Information

Ordering Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Treatment Information

Is patient being treated? ☐ Outpatient ☐ Inpatient

If inpatient, anticipated length of stay: _____

Primary Diagnosis: _____

Diagnosis (ICD-10) Code: _____

Surgery (CPT) Code: _____

Date of Surgery: _____

Is procedure related to an accident? ☐ YES ☐ NO

If yes, please indicate date and describe injures from accident: _____

_____

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

_____

_____

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

If yes**,** what conservative medical therapy was used and when? _____

_____

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

Is there documented evidence (i.e., radiographs or appropriate imaging studies) of nasal fracture resulting in significant variation from normal without physical functional impairment? ☐ YES ☐ NO

Is the intent of the surgery to correct the deformity caused by the nasal fracture? ☐ YES ☐ NO

Is any portion of this surgery for cosmetic purposes? ☐ YES ☐ NO

Plan of Treatment: _____

Additional Comments

_____

_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____