Louisiana HMO, Inc.

REQUEST FOR INITIAL PRECERTIFICATION REVIEW

Date:_____ **Outpatient:**_____ **Inpatient:**_____

Patient's Name_____ **Member #**_____ **Group #**_____

Patient's Address_____ **DOB**_____

Hospital Name_____ **Phone #** _____

Hospital Address_____

Physician Name_____ **Phone #**_____

Physician Address_____

Office Contact Person_____

Admissions Date_____ **Anticipated Length of Stay**_____

Admitting DX/ICD-10 Code_____

Surgery/CPT Code_____ **Date of Surgery**_____

Related HX/Current Signs/Symptoms_____
_____
_____
_____
_____

Lab Findings_____

X-Ray/Diagnostic Findings_____

Current Medications/Freq._____

Plan of Treatment_____
_____
_____

FOR OFFICE USE ONLY: Date Received_____ by (initials) Date Referred for Review_____

Rev. Initials _____ Reference ID # _____ Date of PX Notification _____ Office Contact _____