care n care
Insurance Company, Inc.

Care Management

PHONE: 855-359-9999 FAX: 888-965-1964

☐ Pre-Certification ☐ Referral/Notification

Health Plan/Payor:

☐ Care N' Care PPO ☐ Care N' Care HMO

Submitted by:(select one) ☐ PCP Office ☐ Specialist Office Today's Date: / /	
Person to contact for this Submission:	
Phone:	Fax:

Patient's Name: DOB / / Member ID:	
Patient PCP:	NPI:

Proposed Date of Service: / /	
Treating Provider:	NPI:
Other Provider Name: (i.e. Facility)	NPI:
Phone:	Fax:
☐ Outpatient ☐ Office ☐ Inpatient	

ICD-10 CM Diagnosis Description	ICD-10 CM Code

Procedure: CPT/HCPCS Exact Description	CPT/HCPC Code	# of Visits

Enter any notes pertinent to this standard request: PLEASE SUBMIT CLINICAL DOCUMENTATION WITH ALL PRECERTIFICATION SUBMISSIONS

FOR EXPEDITED REQUESTS ONLY. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function (Please do not use this space for standard request notes):

_____

_____

_____

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.

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