care n care
Insurance Company, Inc.

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Care Management

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

☐ Pre-Certification ☐ Referral/Notification

Health Plan/ Payor: ☐ Care N' Care HMO ☐ Care N' Care PPO

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	CD-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):