

Silverback Care Management

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

Pre-Certification

Referral/Notification

Health Plan/Payor:

United Healthcare

Care N' Care PPO

Care N' Care HMO

Humana Gold Plus

Submitted by:(select one) <input type="checkbox"/> PCP Office <input type="checkbox"/> 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:
<input type="checkbox"/> Outpatient <input type="checkbox"/> Office <input type="checkbox"/> 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. Check is requesting an expedited review that meets CMS definition that determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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

CONFIDENTIALITY NOTICE: This fax message, including any attachments, is for the sole use of the intended recipient(s) to which it is addressed and may contain confidential, privileged or proprietary information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, you are not authorized to read, print, retain, copy or disseminate this message, attachments or any part of them. If you have received this message in error, please notify the sender immediately and destroy the original message, attachments, and all copies thereof.