



**Pre-certification Fax Form for Out-of-Area  
INPATIENT Notification Fax No. 915- 298-5278  
Pre-cert Dept. 915-532-3778 X 1500**

PLEASE NOTE: All services requiring pre-certification (other than on an emergency basis) must be approved in advance by a HMO Medical Director/designee. Pre-certification is subject to all terms and conditions of the Health Service Contract and is only valid for eligible health plan member at time of service.

<b>FACILITY NAME:</b>	_____		
<b>FACILITY ADDRESS:</b>	_____		
	_____	_____	_____
	City	State	Zip Code
<b>TPI #:</b>	_____	<b>NPI #</b>	_____
<b>CONTACT PERSON:</b>	_____		
<b>PHONE:</b>	_____	<b>FAX:</b>	_____
<b>PROCEDURE CODES (CPT CODE):</b>	_____		
<b>IF PATIENT IS TRANSFER, FROM WHAT FACILITY:</b>	_____		
<b>PATIENT ARRIVED BY:</b>	<input type="checkbox"/> AIR AMBULANCE	<input type="checkbox"/> LAND AMBULANCE	<input type="checkbox"/> PRIVATE TRANSPORT <input type="checkbox"/> OTHER
<b>OTHER INSURANCE:</b>	_____	<input type="checkbox"/> SSI	

**NOTE: PLEASE FAX INITIAL CLINICAL INFORMATION WITHIN 24 HOURS OF ADMISSION TO THE UM UNIT AT 915-298-5278, FAILURE TO DO SO MAY RESULT IN DELAY OR DENIAL OF AUTHORIZATION. EL PASO FIRST REQUESTS SUBSEQUENT CLINICAL INFORMATION EVERY OTHER DAY.**

<b>MEMBER NAME:</b>	_____	<b>MEMBER I.D.:</b>	_____
<b>DOB:</b>	_____	<b>MR #</b>	_____ <b>ACCT #</b>
<b>ADMIT DATE:</b>	_____	<b>RM #</b>	_____ <b>DISCHARGE DATE (if applicable):</b>
<b>ADMITTING PHYSICIAN:</b>	_____	<b>ADMITTING DIAGNOSIS (ICD-9):</b>	_____
<b>OTHER DIAGNOSIS (ICD-9):</b>	_____		

<b>ADMITTING Physician's Name:</b>	_____		
<b>TPI #:</b>	_____	<b>NPI #</b>	_____
<b>CONTACT PERSON:</b>	_____		
<b>PHONE:</b>	_____	<b>FAX:</b>	_____
<b>PROCEDURE CODES (CPT CODE):</b>	_____	<b>TYPE OF SERVICE:</b>	_____

<b>SURGEON'S Name:</b>	_____		
<b>TPI #:</b>	_____	<b>NPI #</b>	_____
<b>CONTACT PERSON:</b>	_____		
<b>PHONE:</b>	_____	<b>FAX:</b>	_____
<b>PROCEDURE CODES (CPT CODE):</b>	_____	<b>TYPE OF SERVICE:</b>	_____

<b>OTHER Physician's Name:</b>	_____		
<b>TPI #:</b>	_____	<b>NPI #</b>	_____
<b>CONTACT PERSON:</b>	_____		
<b>PHONE:</b>	_____	<b>FAX:</b>	_____
<b>PROCEDURE CODES (CPT CODE):</b>	_____	<b>TYPE OF SERVICE:</b>	_____

THIS PRECERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS NOR VERIFY ELIGIBILITY. PAYMENT OF BENEFITS IS SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE MEMBER'S CONTRACT. REGARDLESS OF A DETERMINATION, MEDICAL, DECISIONS REGARDING A COURSE OF TREATMENT ARE SOLELY BETWEEN THE PHYSICIAN AND THE PATIENT.