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Coversheet

Fax back coversheet for Provider or Facility to submit Medical Necessity Review request (please utilize this coversheet when faxing back your request)

Date:	Sender Name:	
To: <i>UM Intake Team - MedCom</i>	Sender Phone Number:	
Department: <i>UM Department- Precert review</i>	Department:	
Fax: 1-509-328-9777	Fax:	
Patient:	Patient DOB:	Total # Pages:

☐

Urgent



For Review

☐

Please Reply



Confidential

Message:

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PLEASE FAX INFORMATION TO:

Fax: 1-509-328-9777 or Secure Email: UMFax@personifyhealth.com

Please do not fax photographs

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) and HITECH Privacy Rules. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited by state and federal law and may subject you to civil and criminal penalties. Please notify the sender by telephone (800) 442- 7247 to arrange the return or destruction of the information and all copies.

REV: 09/2025

Precertification Request Form

☐ Routine ☐ Urgent

Contact Information												
Date:				Referral Coordinator:				From:	☐ Facility	☐ Provider		
Phone:				Ext:				Fax:				
Patient Information												
Patient Name:						DOB:			Phone:			
Employee ID #:				Employee Name:								
Address:						City:			State:		ZIP:	
Patient has other insurance?	☐ Yes	☐ No	Name of Other Insurance:									
Did you call in for precert?	☐ Yes	☐ No	If yes: Date:			Time:			Time Zone:			
Facility Information												
Facility Name:						Tax ID:			NPI:			
Address:						City:			State:			
Phone:				Fax:					Zip:			
Attending Physician												
Physician Name:				Specialty:				NPI:				
Address:						City:			State:			
Phone:				Fax:					Zip:			
Requested Services												
Provide at least one code in each of the following sections as well as a brief description of services requested.												
ICD-10 Codes:												
CPT/HCPCS:												
Description:												
Outpatient	☐ Yes	☐ No	Date of Service:									
Inpatient	☐ Yes	☐ No	Admit Date:									
From:			To:			Days/visits:			DME Purchase:			
									DME Rental:			

Please complete form and return with any supporting clinical documentation to: Fax:

1-509-328-9777 or Secure Email: UMFax@personifyhealth.com

For questions, please contact customer service via phone. The number can be found on the back of the ID card.

IMPORTANT NOTICE

*Note: Use of non-network providers may result in a reduction of benefits payable by the Health Plan. Please ensure that all providers of service are participating in the Network assigned by your Health Plan, as this is subject to change. The Health Plan sponsored by the above Employer Group has certain provisions requiring medical necessity review. Please be advised that our Utilization Management Program cannot deny medical attention. Precertification involves a review of medical necessity only and does not guarantee payment or confirm coverage. Benefit payments are based on eligibility and the Schedule of Benefits under the Plan at the time of service, and are subject to all Limitations and Exclusions, including limitations and exclusions for Pre-Existing conditions. Please review your Plan Document or contact Customer Service regarding Benefits and Eligibility questions.

Revised 09/2025