Medical Coverage Determination Form

Please complete this form and fax to:

910-239-8293

MEMBER INFORMATION

Member ID#: _____

Member Name: _____

Member Representative: _____

Date of Birth: _____

Phone Number: _____

PROVIDER INFORMATION

Provider Name:_____Provider NPI: _____

Facility Name:_____Phone #: _____

Members PCP: _____

SERVICE INFORMATION

Type of Service requested:

Outpatient Hospital	Ambulatory Surgery	Diagnostic Radiology
Part B Medication	DME item over $250	Therapy after 14 visits
Home Health after 14 visits	Out-of-Network Request	

Service Requested: _____

Service # of visits/Frequency: _____

CPT Code(s) (List all): _____

HCPCS Code(s) (List all) : _____

ADDITIONAL INFORMATION

Additional Notes:

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