



# SHARP Health Plan

**OFFICE USE ONLY**  
 Eligibility verified:  
 Yes  No

## Precertification Form

### Point of Service (POS) Plan and Preferred Provider Organization (PPO) Plan

<p><b>Purpose</b></p> <p>The purpose of this form is to request precertification for a Sharp Health Plan POS or PPO Plan member to receive health services from an out-of-network provider.</p> <p><b>Instructions</b></p> <ul style="list-style-type: none"> <li>• Please validate member eligibility and benefits prior to rendering services.</li> <li>• Attach all applicable clinical documentation such as progress notes, labs or radiology.</li> </ul>	<p><b>Submit</b></p> <p>Please fax your finished form and required documents to:</p> <p> Attention: Medical Management 1-619-740-8111</p> <p><b>Payment for services is dependent upon the member's eligibility at the time services are rendered. Copays, coinsurance and/or deductibles may apply. Precertifications are valid for the date range specified on the approval letter.</b></p>
<p> <b>Need help?</b> Call Customer Care at 1-800-359-2002, or email customer.service@sharp.com with your message. We're available to assist you Monday through Friday, 8 a.m. to 6 p.m.</p>	

<b>Member information</b> Please check one: <input type="checkbox"/> POS <input type="checkbox"/> PPO				
First name:		Last name:		Middle initial:
ID#:		Phone number:		Birth date (MM/DD/YY):
Home address:				
City:		State:		ZIP code:
<b>Requesting provider information</b>				
Requesting provider's name:		Phone number:		Fax number:
Address:				
City:		State:		ZIP code:
NPI#:	Member requested? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Prepared by:	Date sent (MM/DD/YY):
<input type="checkbox"/> <b>Routine / Standard Request:</b> Decisions will be rendered within 5 business days from receipt of all necessary information. <input type="checkbox"/> <b>Urgent Request:</b> Decisions will be rendered within 72 hours from receipt of all necessary information. A request is urgent if waiting five days would seriously jeopardize the member's life or health or the member's ability to regain maximum function or, in their doctor's opinion, subject the member to severe pain that cannot be adequately managed without the care or treatment that is being requested.				
<b>Servicing provider/facility information</b>				
Servicing provider/facility name:		Phone number:		Fax number:
Address:				
City:		State:		ZIP code:
Tax ID:	NPI#:	Expected date of service (MM/DD/YY):		Inpatient length of stay:

**Servicing provider/facility information, continued**

Diagnosis	ICD-10 Code	Procedure and Equipment	Procedure Code	Units

**Reason for request (Please submit all pertinent documentation with request.):**

**IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002. IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.**