IMPORTANT: Incomplete forms will be faxed back to sender.

SHARP HEALTH PLAN

Precertification Form
Point of Service (POS) Plan

OFFICE USE ONLY
Eligibility verified:
☐ Yes ☐ No

Purpose
The purpose of this form is to request precertification for a Sharp Health Plan POS Plan member to receive health services from an out-of-network provider.

Instructions
- Please validate member eligibility and benefits prior to rendering services.
- Attach all applicable clinical documentation such as progress notes, labs or radiology.

Submit
Please submit the finished form and required documents by fax:

By Fax:
Attention: Medical Management
1-619-740-8111

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.

Member Information

First name:	Last name:	Middle initial:
ID#:	Phone number: 1- - -	Birth date (MM/DD/YY): (/ /)
Home address:		
City:	State:	ZIP code:

Requesting Provider Information

Requesting provider's name:		Phone number: 1- - -	Fax number: 1- - -
Member requested? ☐ Yes ☐ No	☐ Inpatient ☐ Outpatient	Prepared by:	Date sent (MM/DD/YY): (/ /)

☐ **Routine / Standard Request:** Decisions will be rendered within 5 business days from receipt of all necessary information.

☐ **Urgent Request:** 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.

Servicing Provider Information

Servicing provider's name:	Phone number: 1- - -	Fax number: 1- - -
Address:		
City:	State:	ZIP code:

Tax ID:	NPI:	Expected date of service (MM/DD/YY): (/ /)	Inpatient length of stay:

Diagnosis	ICD-10 Code	Procedure and Equipment	Procedure Code	Units

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

For Sharp Health Plan UM Use Only

Precertification number:	Date Range (MM/DD/YY): (/ /) – (/ /)	Initials:	☐ Approved ☐ Denied

☐ Pend for additional information ☐ POS Retro-approval (services rendered without a precertification)

Comments:

If you need assistance, we're here to help. You can call Customer Care at 1-800-359-2002, or email us at **customer.service@sharp.com.** We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

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.