Horizon Casualty Services, Inc.

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Horizon Casualty Services, Inc.
P.O. Box 10175
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1-800-985-7777
HorizonCasualty.com

PROCEDURE/SURGERY AND AFTER CARE PRE-CERTIFICATION FORM

Date _____ Physician Office Contact _____ Phone # _____ Fax # _____

Instructions:

- Surgery must be scheduled with network surgeon and assistant at an in-network hospital or ASC.
- Please fax all physician records supporting the pre-certification request to the HCS Nurse Case Manager.
- Fax completed form to:

Case Manager _____ Phone # _____ Fax # _____

Patient Information

Patient Name _____ Date of Injury _____ Claim # _____

Proposed Treatment

Primary ICD Code(s) & Description _____ (R) ☐ (L) ☐

Requested Surgery Date _____ First Post Op Visit Date _____

Requested Procedure(s) _____

Surgery CPT Code(s) _____

Intraoperative Neuromonitoring (IONM): Y/N IONM CPT Code(s) _____

Projected Return to Work Date(s): Light Duty _____ Full Duty _____

Provider Type	Provider/ Group Name	TIN
Surgeon/Physician		
Assistant/ Co-Surgeon		
Anesthesia		
IONM		

Facility Type	Facility Name	Location	Length of Stay
Hospital			
ASC			N/A

Additional Services	Details	
OT and/or PT	Start Date:	Duration/Frequency:
DME	Purchase or Rental:	Description:
Other		