



Horizon Blue Cross Blue Shield of New Jersey

Fax Medical Necessity Determination Request Cover Sheet

Please attach all relevant medical records that support this request.

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

	Fax No.
Diagnosis of Obstructive Sleep Apnea	1-888-608-1015

Patient/Subscriber Information:

Patient Name: _____ ID#: _____
Last First MI

DOB: ____ / ____ / ____ Gender: M F
MM DD YYYY

Subscriber Name: _____
Last First MI

Relationship to patient: Self Spouse Child Is there any other Insurance? Yes No If so, name of other insurance carrier: _____

Physician Information:

Ordering Physician: _____ PCP or Specialist NPI/TIN#: _____

Contact Person: _____ Phone #: _____ - _____ - _____ Ext: _____ Fax #: _____ - _____ - _____

Office Location: _____ Was patient referred by PCP? Yes No If the physician in non par, is the member aware? Yes No

Service That Medical Necessity Determination Is Being Requested:

Provider Services 1-800-624-1110 should be contacted to verify member eligibility.

Procedure: _____ CPT4: _____ DX/ICD-9: _____ DX/ICD-10: _____

Anticipated Date of Service: ____ / ____ / ____ Facility/Location: _____
MM DD YYYY

STAT requests can only be made by the ordering physician, where the physician indicates (and supplies supporting documentation) that applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Any request for retrospective Medical Necessity Determination will not be considered on a STAT basis.

Additional information pertinent to this Request: _____

Medical Necessity Determination Status:

Approved: _____ Reference #: _____ *Expiration Date: ____ / ____ / ____ Date Medical Necessity Determination completed: ____ / ____ / ____
MM DD YYYY MM DD YYYY

Denied: _____ Reason: _____ By: _____ Ext: _____

Pended: _____ For additional medical information For medical Review Information By: _____ Date: ____ / ____ / ____
MM DD YYYY

Comments: _____

*** This determines the medical necessity of the services requested based upon the information provided. It is NOT a guarantee of payment. It is issued subject to the terms and limitations of your agreement and the member's benefit plan, and subject to the member being eligible at the time services are provided. We reserve the right to deny reimbursement in the event of fraud or misrepresentation or if there is a material change in facts and circumstances that varies from the information that was provided with the original request.**

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