Please fax this completed form and any available office notes and diagnostics to Core Health Benefits. Pathologies if available.

Core Health Benefits
PO Box 90
Macon, GA 31202
Tel: 478-741-3521, 888-741-2673,
Fax: 478-745-1843

Precertification Request	
Required Information: Member Demographics	(Please verify eligibility prior to rendering service).
Name:	Date of Birth:
Employer:	Insurance ID #:
Other Insurance:	Core is Primary ___ Secondary ___
Required Information: Provider Information:	
Provider Name:	Tax ID#: (Not NPI)
Facility (where procedure or surgery will be performed)	Tax ID#:
Contact Person:	CONTACT PHONE/EXTENSION
Contact Fax:	
Required Information: Procedural	
Date of Service:	
Diagnosis Codes: (ICD-10)	Procedure Codes: CPT
Inpatient? Y N	
For Core Health Benefits use only below this line:	
Medical Director Determination: Approved _____ Denied _____	Reason for Denial:
Authorization #:	