


Please email this completed form and scan & attach any office notes, pathologies, and diagnostics to: precert@secure.corehealthbenefits.com.

Please note only PDF scans will be accepted. Additionally, files larger than 10mb may be rejected from this inbox.

	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 #:			