brms™
Benefit & Risk Management Services

CERTIFICATION REQUEST FORM

Review determination is based on medical policy utilization and is a guide in evaluating the medical necessity of a particular service or treatment. BRMS adopts policies after careful review of published peer-reviewed scientific literature; national evidence based medical guidelines and local standards of practice. Since medical technology is constantly changing, BRMS reserves the right to review and update policies as appropriate. ***Member contracts differ in their benefits.*** **Always consult the member benefit booklet or contact a member service representative at 800-959-4767, OPTION #1 to determine coverage for a specific medical service or supply.**

All fields need to be FILLED OUT COMPLETELY in order to be considered for completion of authorization. WHEN COMPLETE, fax this form ATTN to: BRMS/UR DEPT at fax number 916-467-1403.

PLEASE TYPE OR PRINT

REQUESTING MEDICAL OFFICE	
DATE:	CONTACT NAME:
CONTACT PHONE: ( )	CONTACT FAX: ( )

PATIENT/ SUBSCRIBER INFORMATION	
PATIENT NAME:	PATIENT DATE OF BIRTH: / /
SUBSCRIBERS (INSURED) NAME:	**SUBSCRIBERS ID Number** | | | | | | | | |
SUBSCRIBERS (INSURED) EMPLOYER	

REQUESTED DIAGNOSIS/PROCEDURE INFORMATION						
DIAGNOSIS CODES (ICD-9)	1.	2.	3.	4.		
PROCEDURE CODE(S) (CPT)	1.	2.	3.	4.	5.	6.
DATE OF SERVICE/ADMISSION: / /	LENGTH OF STAY (Fill out for inpatient only)					

CLINICAL HISTORY/SYMPTOMS:
(Must attach copies of any supporting MD notes, labs, H&P, and diagnostic procedures pertaining to auth request. NOTE: Durable Medical equipment requires pricing.)

**** PATIENT: Height _____ Weight_____ ** Clinical Trial ? (Check one) YES ☐ NO ☐**

PHYSICIAN INFORMATION	
PHYSICIAN NAME:	**TAX ID:** | | | | | | | | |
ADDRESS	

PLEASE VERIFY BENEFITS with the Benefits Department that the facility/hospital listed below is a contracted service provider.

HOSPITAL /FACILITY NAME: (location procedure will take place)	**TAX ID:** | | | | | | | | |
ADDRESS	