

SURGERY PRE-CERTIFICATION REQUEST FOR NJ NO-FAULT CLAIMS

(This does not apply to EMERGENCY PROCEDURES)

Fax 1-866-841-8312

Request date: _____

Patient name: _____

Physician name: _____

Claim no.: _____

Telephone no.: _____

Date of injury: _____

Fax no.: _____

Please complete below.

**Include documentation to support the need for and causal relationship of surgery
(e.g., MRIs, CT scans, discogram, EMG, and most recent office notes).**

Surgical procedure description: _____

CPT/Procedure code(s)*: _____

*Subject to review and substantiation with operative report.

ICD diagnosis code(s): _____

Name of hospital or ASC where procedure will be performed: _____

Please check the appropriate box:

I do not anticipate requiring an assistant surgeon or co-surgeon.

I propose using a co-surgeon/assistant surgeon/physician assistant/RNFA (circle the one that applies)**

Name: _____

I propose using two or more surgeons. Name(s)/Role(s): _____

Post-operative care beyond that included in the global fee package is required (specify type of care/svcs [i.e., PT w/frequency and duration, DME, etc.]**

Inpatient admission required Same Day Surgery Proposed Surgery Date: _____

****REQUESTS FOR CO-SURGEONS AND ASSISTANT SURGEONS MUST MEET CMS GUIDELINES.**

Pursuant to N.J.A.C. 11:3-29.4 et seq., global fee periods and the necessity for co-surgeons and assistant surgeons will be determined based upon the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule and Medicare Claims Manual, which can be found at www.cms.gov.