Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

A division of Family Guardian Insurance Company Ltd. *Please type or print.*

PRECERTIFICATION, REFERRAL, HOSPITALIZATION REQUEST

Date: _____ **Member's Name:** _____

Patient's Name: _____ **D.O.B** MM DD YY **PT's ID#:** _____

Street Address: _____ **P.O. Box:** _____

Telephone No(s): Work _____ Cell _____ **Fax No:** _____

Email Address: _____

Physician's Name: _____

Telephone No(s): Work _____ Cell _____ **Fax No:** _____

Provider Information

Attending Physician: **Tel. No(s):** **Fax No(s):**

Referring Physician: **Tel. No(s):** **Fax No(s):**

History

Date of Onset:

Physical Findings

Diagnosis

Proposed Procedure

- **ICD-9-CM Code(s):** _____ • **CPT Code(s):** _____
- **Admitting Hospital:** _____ • **Expected Length of Stay:** _____
- **Date of Admission:** _____ • **Date of Surgery:** _____
- **Estimated Cost** $ _____ *R & C applies*

Authorized Signature: _____

FOR INTERNAL USE

- **Pre-certification #:** _____ Date Obtained: Date Expires:
- **Comments:** _____

IMPORTANT NOTICE / DISCLAIMER, PLEASE READ

This Authorization is for medical necessity decisions only and is not a guarantee of coverage for pre-existing conditions or any other conditions not covered under the contract. The Approval expires 30 days from the date it was granted and is subject to the Member's eligibility and contractual provisions. Please contact our HealthCare Coordinators at 396-1303-6 and Family Island toll free 242-300-2458 for any further assistance required from Monday through Friday between the hours of 9am -5pm. Kindly submit all requests to fax # 396-1363 or Precerts@familyguardian.com