Confidential Pursuant to Section 2805(M) of The Public Health Law

PRE-ADMISSION CERTIFICATION FORM

This form and the required documentation applies to all Medicare and Medicaid patients having any of the elective surgical procedures listed below to certify medical necessity. It is to be completed by the Surgeon and faxed to MMF. Completed material is due one week but not later than 3 days prior to scheduled admission; delay will result in rescheduling the procedure.

All fields are required. **MMF Fax # is 866-333-0174.**

Patient Last Name: **First Name:**

DOB: month day year Age: **Gender:** ☐ **Male** ☐ **Female**

Expected Admit Date: **Medical Record #, if available:**

Attending Physician: **Assistant/Resident:**

Office Contact / phone:

Payment Source: **Medicare** **Medicaid**

Admitting Diagnosis:

I. **Check the procedure and submit** .... **Required documentation to support medical necessity:**

Procedure	Required documentation
Rhinoplasty:	Radiology exam and/or documentation that support medical necessity
Septoplasty or SMR of Inferior Turbinates:	Radiology exam and/or documentation that support medical necessity
Blepharoplasty Right Eye Left Eye Both:	Photos* & Visual Fields
Ptosis Right Eye Left Eye Both:	Photos* & Visual Fields
Plastic Surgery - Facial / Breast:	Documentation to support medical necessity
Excision of Eyelid / Skin / Subcutaneious Lesion / Keloid:	Documentation to support need for hospital vs office procedure
Eye Muscle Surgery (Adult patient only):	Photos* or ocular measurements & patient's symptoms
Laser treatment for Vascular Hematoma or Capillary Vascular Malformation:	**Document size of lesion, Photos * if available**

***Patient's name and date of birth must be printed on the photo**

II. **Clinical statement to justify admission including relevant medical history, clinical and diagnostic findings:**

____

____

Physician Signature **Print name** **Date / Time**

NY Eye & Ear Quality Office Review of medical documentation:

Certified Denied and reason for denial ______________________

If Medicare is denied, the Admitting Department must have patient sign ABN (Advance Beneficiary Notice)

Reviewers Signature: *Print Name* *Date*

Contact NYEE Quality Department at 212-979-4461 if you have any questions.