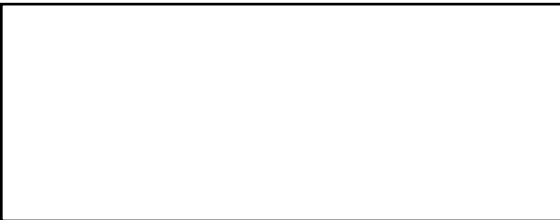




PRE-ADMISSION CERTIFICATION FORM



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:
- | | | | | |
|---|-----------|----------|-------|--|
| 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 / Subcutaneous 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.