Please email this completed form and scan & attach any office notes, pathologies, and diagnostics to: precert@secure.corehealthbenefits.com.

Please note only PDF scans will be accepted. Additionally, files larger than 10mb may be rejected from this inbox.
A valid email address MUST be supplied for provider contact. THIS FORM WILL NOT BE PROCESSED WITH AN INVALID EMAIL.

Core Health Benefits
PO Box 90
Macon, GA 31202
Tel: 478-741-3521, 888-741-2673,
Fax: 478-745-1843

Precertification Request

Required Information: Member Demographics	(Please verify eligibility prior to rendering service).
Name:	Date of Birth:
Employer:	Insurance ID #:
Other Insurance:	Core is Primary ☐ Secondary ☐
Required Information: Provider Information:	
Provider Name:	Tax ID#: (Not NPI)
Facility (where procedure or surgery will be performed)	Tax ID#:
Contact Person:	Contact Phone / Extension:
Contact Email:	Contact Fax:
Required Information: Procedural	
Date of Service:	
Diagnosis Codes: (ICD-10)	Procedure Codes: CPT
Inpatient? Y ☐ N ☐	
For Core Health Benefits use only below this line:	
Medical Director Determination: Approved _____ Denied _____	Reason for Denial:
Authorization #:	