Preauthorization Request Form

Preauthorization Policy

All non-emergent inpatient and outpatient services provided overseas require preauthorization by NHI. Specified non-emergent inpatient and outpatient services provided on-island also require preauthorization by NHI (see benefit schedule). In an emergency situation, where preauthorization is not possible, the provider may request retrospective authorization. Providers will not bill beneficiaries for a service requiring preauthorization if the authorization was not obtained or was denied unless the provider has written consent from the beneficiary to proceed with obtaining the service and the beneficiary is aware that the service is not covered by NHI and that they will be responsible for payment.

Send completed request form and chart notes to
NHI: 494-6022 (Fax #) or NHIClinical@vinhi.vg(Email)

Provider & Service Information

Date: M ____ D ____ Y_____

Requesting Provider: _____ Provider Phone: _____

Primary Care Provider: _____ PCP Phone: _____

Service or Procedure Requested: _____ Service/ Procedure ICD or CPT Code : _____

Date of procedure or number of visits requested : _____ Date Span requested: _____

Facility or Agency: _____ Inpatient, Outpatient or Home? _____

Routine or Urgent Request? _____ Emergency/ Retrospective Request? _____

If Emergency/ Retrospective request, explain: _____

_____

_____

_____

Beneficiary Information

Name: _____

D.O.B M____ D ____ Y_____ NHI ID# _____ Phone: _____

Address: _____

Reason for Request:

(Summarize and attach clinical documentation, medical report and test results where necessary. Clinical signs and symptoms – frequency, severity, duration, tests done, treatment given, aggravating or alleviating factors, etc.)

Is illness related to motor vehicle accident and/or work-related injury? Please explain.

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Provider Certification: I hereby attest that the services for which this [referral/submission for pre-authorization] is made (i) are appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition; (ii) provide for the diagnosis or the direct care and treatment of a medical condition; and (iii) are not primarily for the convenience of the Beneficiary, and Beneficiary's attending or consulting physician, or another health care provider.

_____

Provider Signature & Date

For NHI Use Only

Date Received: _____

Approved or Denied? _____ Authorization # _____

Date Entered: _____ Staff Member: _____

Submit