

PAR: #

# Pre-Authorization Approval for Medical Services

## SECTION 1: FACILITY/PROVIDER INFORMATION

### Facility/Provider Information

Contact:	
Physician Name:	
Practice /Hospital Name:	
Practice /Hospital Address:	
Practice /Hospital Phone Number:	
Practice /Hospital Fax Number:	
Practice /Hospital Email:	
<b>Place of Service Information</b>	
Place of Service Contact:	
Place of Service Name:	
Address for Place of Service:	
Place of Service Phone Number:	
Place of Service Fax Number:	
Place of Service Email:	

If you use encrypted email send information to Pre-Authorization Email: [preauth@mynovahealthcare.org](mailto:preauth@mynovahealthcare.org)

Otherwise please fax to 805-375-6090

## SECTION 2: NOVAHEALTHCARE CONTACT INFORMATION

### NOVA HEALTHCARE INFORMATION

Pre-Authorization Email:	<a href="mailto:preauth@mynovahealthcare.org">preauth@mynovahealthcare.org</a>
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<b>Company Name:</b>	<b>NOVA Pathfinder Limited a Healthcare Company</b>
<b>Address:</b>	<b>5739 KANAN ROAD Suite #335 AGOURA, CA 91301</b>
<b>From:</b>	<b>NOVA Pathfinder Limited a Healthcare Company Preauthorization Department</b>
<b>Approval Date:</b>	
<b>Pre-Authorization Phone # and Extension:</b>	<b>801-948-9938 Ext 108</b>
<b>Toll Free Phone:</b>	<b>1-888-266-4462</b>
<b>Fax:</b>	<b>1-805-375-6090</b>
<b>Website:</b>	<b>https://mynovahealthcare.org</b>
<b>Claims Email:</b>	<b>claims@mynovahealthcare.org</b>

**SECTION 3: PATIENT INFORMATION**

<b>Patient Information</b>	
<b>Member Full Name:</b>	
<b>Plan Member Address:</b>	
<b>NOVA Member ID:</b>	
<b>DOB:</b>	
<b>Phone Number:</b>	
<b>Email:</b>	

NOTE TO PHYSICIAN: You are responsible for providing true, accurate and complete information concerning the applicable diagnosis and procedure codes and the patient's medical record and ensuring the medical necessity of the procedure. \*\* The provider is responsible for verifying payer policy as to the appropriate code used for describing each type of implantable pulse generator. Please validate that the codes to be approved & billed for all services professional and facility services are correctly reflected.

**Pursuant to medical request for our member listed above NOVA Pathfinder Limited a Healthcare Company hereby approves request for:**

**SECTION 4: CPT/HCPCS INFORMATION**

<b>CPT/HCPCS CODES</b>	<b>DESCRIPTION</b>	<b>UNITS</b>	<b>COST</b>	<b>MEDICAL NECESSITY</b>
	PHYSICIAN			
	PROCEDURE			
	FACILITY			
	ANESTHIA			
	MISC			

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**ALL CPT CODES RELATING TO THIS PROCEDURE MUST BE PROVIDED OR CHARGES WILL NOT BE CONSIDERED**

SECTION 6: DIAGNOSIS CODES INFORMATION			
ICD-10 CODES	DESCRIPTION	CPT/HCPCS Or PX or DRG	ASSOCIATED TO CPT OR DRG /PROCEDURE CODES

**DRG AND PX CODES**

SECTION 7 (a): PRICE IS INCLUDED IN DRG			
PROCEDURE CODES	DESCRIPTION	POINTER TO DIAGNOSIS CODES	UNITS

SECTION 7 (b): PRICE IS INCLUDED IN DRG			
DRG CODE	DESCRIPTION	UNITS	TOTAL ALLOWED

**ALL MEDICAL RECORDS, H&P, LABS, DIAGNOSTIC MUST BE RECEIVED FOR PRE-AUTHORIZATION TO BE CONSIDERED**

SECTION 8: TOTAL ALLOWED AMOUNT FOR ALL SERVICES		
Total Approved for Allowed Amount:	\$ <input type="text"/>	Provider agrees to not balanced bill Member.

The Provider and facility will hold harmless NOVA Pathfinder Limited a Healthcare Company against any claims outside of this request.

Become an In-Network Provider? Our process is easy...			
Do you want to Explore being an In-Network Provider?	YES	No	<input type="text"/>

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<b>Contact Name</b>			
<b>Authorized Contact to be Approved Contact for In-Network Agreement?</b>	<b>YES</b>	<input type="checkbox"/>	<b>No</b>
<b>Contact Phone Number:</b>			
<b>Contact Email:</b>			
<b>Contact Fax Number:</b>			

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