NJM Insurance Group
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SURGERY PRE-CERTIFICATION REQUEST FOR NJ NO-FAULT CLAIMS

(This does not apply to **EMERGENCY PROCEDURES**)

Request Date:	______	Patient Name:	______
Physician Name:	______	Claim #:	______
Telephone #:	______	Date of Injury:	______
Fax #:	______	Adjuster Name:	______
	______	Adjuster Fax #:	______

Please complete the fields below

Include documentation to support the need for and causal relationship of surgery
(e.g.: MRIs, CT scans, Discogram, EMG and most recent office notes.)

Surgical Procedure Description:				
CPT/Procedure Code(s)*:				***Subject to review and substantiation with operative report.**
ICD-9 Diagnosis Code(s):				
Name of Hospital or ASC where procedure will be performed:				
†Please check the appropriate box:				
☐	**I do not anticipate requiring an assistant surgeon or co-surgeon.**			
☐	**I propose using a co-surgeon/assistant surgeon/physician assistant/RNFA (circle the one that applies)†.** **Name:**			
☐	**I propose using two or more surgeons. Name(s)/Role(s):**			
☐	**Post-operative care beyond that included in the global fee package is required (Specify type of care/svcs [i.e. PT w/frequency and duration, DME, etc.])†.**			
☐	**Inpatient admission required.**	☐	**Same Day Surgery**	**Proposed Surgery Date:**

†REQUESTS FOR CO-SURGEONS AND ASSISTANT SURGEONS MUST MEET CMS GUIDELINES

Pursuant to N.J.A.C. 11:3-29.4 et seq., global fee periods and the necessity for co-surgeons and assistant surgeons will be determined based upon the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule and Medicare Claims Manual, which can be found at www.cms.gov.