



PIEDMONT COMMUNITY HEALTH PLAN
Community Partners for Quality Healthcare

Re-pricing Pre-certification Form

Piedmont Community Health Plan

- 1. Patient Name:** _____
- 2. PCHP Card Member Number:** _____
- 3. Patient Employer:** _____
- 4. Physician Ordering the Test:** _____
- 5. Specific Test:** _____
- 6. Expected Test Date and Location:** _____
- 7. Working Diagnosis:** _____

Once completed please fax this form to PCHP at 434-947-4465

Piedmont Community Health Plan
1937 Thomson Drive
Lynchburg, VA 24501
434-947-4463 • 800-400-PCHP