PRECERTIFICATION/UTILIZATION MANAGEMENT/PHARMACY PRIOR AUTHORIZATION REQUEST FORM

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SENDER'S INFORMATION

CONTACT NAME: ______________________

CONTACT PHONE #: ______________ EXT: ______ CONTACT FAX #: ______________

PROVIDER OFFICE/FACILITY: ______________________ TAX ID: ______________

PATIENT'S INFORMATION

NAME: ______________________ DATE OF BIRTH: ______________

SOCIAL SECURITY # (last 4 digits): ________ TELEPHONE #: ______________

ADDRESS: ______________________ GROUP #/EMPLOYER: ______________

INSURED'S INFORMATION

NAME: ______________________ DATE OF BIRTH: ______________

SOCIAL SECURITY # (last 4 digits): ________ GROUP #/EMPLOYER: ______________

SERVICE REQUEST

CPT CODE(S): ______________________

TYPE OF SERVICE: ______________

DIAGNOSIS: ______________________

ICD 10 CODE: ______________ DATE OF SERVICE: ______________

FACILITY: ______________________ In-patient Out-patient

ORDERING PHYSICIAN: ______________________ TELEPHONE #: ______________

PHYSICIAN NPI#: ______________

FAX TO PRECERTIFICATION/ UTILIZATION MANAGEMENT:

(828) 670-9159

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