



PLEASE COMPLETE THIS FORM AND ATTACH CLINICALS FOR TIMELY RESPONSE

TO: PRECERTIFICATION/ UTILIZATION MANAGEMENT

FAX: (828) 670-9159

SENDER'S INFORMATION

OF PAGES:

<u>CONTACT NAME:</u>	<u>CONTACT PHONE # & EXT:</u>
<u>PROVIDER OFFICE/FACILITY:</u>	<u>CONTACT FAX #:</u>

PATIENT'S INFORMATION

<u>NAME:</u>	<u>DATE OF BIRTH:</u>
<u>SOCIAL SECURITY #:</u>	<u>TELEPHONE #:</u>
<u>ADDRESS:</u>	<u>CITY & STATE:</u>
<u>GROUP #/ EMPLOYER:</u>	

INSURED'S INFORMATION

<u>NAME:</u>	<u>DATE OF BIRTH:</u>
<u>SOCIAL SECURITY #:</u>	<u>GROUP #/ EMPLOYER:</u>

SERVICE REQUEST

<u>TYPE OF SERVICE:</u>	<u>CPT CODE:</u>
<u>DIAGNOSIS:</u>	<u>ICD 10 CODE:</u>
<u>FACILITY:</u>	<u>DATE OF SERVICE:</u>
<input type="checkbox"/> In-patient <input type="checkbox"/> Out-patient	<u>TELEPHONE #:</u>

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