CRESCENT
HEALTH SOLUTIONS

PLEASE COMPLETE THIS FORM AND ATTACH CLINICALS FOR TIMELY RESPONSE

TO: PRECERTIFICATION/ UTILIZATION MANAGEMENT

FAX: (828) 670-9159

SENDER'S INFORMATION ***# OF PAGES:***

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

PATIENT'S INFORMATION

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

INSURED'S INFORMATION

NAME:	DATE OF BIRTH:
SOCIAL SECURITY #:	GROUP #/ EMPLOYER:

SERVICE REQUEST

TYPE OF SERVICE:	CPT CODE:
DIAGNOSIS:	ICD 10 CODE:
FACILITY: ❑ In-patient ❑ Out-patient	DATE OF SERVICE:
ORDERING PHYSICIAN:	TELEPHONE #: