PRECERTIFICATION/UTILIZATION MANAGEMENT/PHARMACY PRIOR AUTHORIZATION REQUEST FORM

PLEASE ATTACH CLINICALS FOR TIMELY RESPONSE.

ORDERING PROVIDER INFORMATION

SENDER INFORMATION

CONTACT NAME: PHONE: EXT: FAX #:

ORDERING PROVIDER: PROVIDER NPI #:

PRACTICE NAME/ ADDRESS:

TAX ID: PROVIDER NPI #:

PATIENT INFORMATION

NAME: DATE OF BIRTH: SSN# (last 4 digits):

ADDRESS: PHONE #: GROUP #/ EMPLOYER:

INSURED INFORMATION

NAME: DATE OF BIRTH: SSN# (last 4 digits):

PHONE #: GROUP #/ EMPLOYER:

SERVICES TO BE RENDERED

CPT CODE(S): *

TYPE OF SERVICE:

DIAGNOSIS:

ICD-10 CODE:

DATE OF SERVICE: In-patient ☐ Out-patient ☐

FACILITY/LOCATION NAME:

ADDRESS:

NPI: TAX ID: PHONE #:

FAX TO PRECERTIFICATION/ UTILIZATION MANAGEMENT: (828) 670-9159