PRECERTIFICATION/UTILIZATION MANAGEMENT/PHARMACY PRIOR AUTHORIZATION REQUEST FORM

PLEASE ATTACH CLINICALS FOR TIMELY RESPONSE.

 # OF PAGES ATTACHED:

SENDER INFORMATION

CONTACT NAME:

CONTACT OFFICE/FACILITY:

PHONE #:

EXT:

ADDRESS:

FAX #:

TAX ID:

PRACTICE 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:

SERVICE REQUEST

TYPE OF SERVICE:

CPT CODE(S): **ONLY 56 CHARACTERS ALLOWED PER LINE. TEXT DOES NOT WRAP. ATTACH SEPARATE SHEET IF NEEDED.**

DIAGNOSIS:

ICD-10 CODE:

DATE OF SERVICE:

In-patient ☐ Out-patient ☐

FACILITY:

ORDERING PHYSICIAN:

ORDERING PHYSICAN NPI#:

ORDERING PHYSICIAN PRACTICE NAME:

PHONE #:

ADDRESS:

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

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