



PRECERTIFICATION/UTILIZATION MANAGEMENT/PHARMACY PRIOR AUTHORIZATION REQUEST FORM

PLEASE ATTACH CLINICALS FOR TIMELY RESPONSE.

ORDERING PROVIDER INFORMATION

SENDER INFORMATION

CONTACT NAME: _____ PHONE #: _____ EXT: _____
ORDERING PROVIDER: _____ FAX #: _____
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: _____

SERVICE REQUEST

CPT CODE(S): *

TYPE OF SERVICE:

DIAGNOSIS:

ICD-10 CODE:

DATE OF SERVICE:

In-patient

Out-patient

SERVICES TO BE RENDERED AT:

ADDRESS:

NPI:

TAX ID:

PHONE #:

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