



PRECERTIFICATION/UTILIZATION MANAGEMENT/ PHARMACY PRIOR AUTHORIZATION REQUEST FORM

****ATTACH CLINICALS FOR TIMELY RESPONSE.****

OF PAGES: _____

SENDER INFORMATION

CONTACT NAME: _____
CONTACT PHONE #: _____ EXT: _____ CONTACT FAX #: _____
PROVIDER OFFICE/FACILITY: _____
TAX ID: _____

PATIENT INFORMATION

NAME: _____
SOCIAL SECURITY # (last 4 digits): _____ DATE OF BIRTH: _____ TELEPHONE: _____
ADDRESS: _____
GROUP #/EMPLOYER: _____

INSURED INFORMATION

NAME: _____
SOCIAL SECURITY # (last 4 digits): _____ DATE OF BIRTH: _____
GROUP #/EMPLOYER: _____

SERVICE REQUEST

TYPE OF SERVICE: _____ DIAGNOSIS: _____
CPT CODE(S): ****TEXT DOES NOT WRAP. ATTACH SEPARATE SHEET IF NEEDED.**** _____
ICD-10 CODE: _____ DATE OF SERVICE: _____ Inpatient _____ Outpatient _____
FACILITY: _____
ORDERING PHYSICIAN: _____ TELEPHONE: _____
PHYSICIAN NPI#: _____

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

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