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

Crescent Health Solutions 1200 Ridgefield Blvd. Ste. 215 Asheville NC 28806-2292 Telephone 828-670-9145 Fax 828-670-9155