PLEASE COMPLETE FORM AND
ATTACH WITH CLINICAL RECORDS

Please contact the benefit department via the phone number on the insureds medical ID card for benefits on the procedure you are inquiring on to determine if prior authorization is required. The benefit department would advise level of coverage or if care is non-covered within the plan the patient has.

To: PRIOR AUTHORIZATION DEPT
From: ________________________

Patient name: _______________________________ **Patient's DOB:** _____________
ID # _______________ **Group #**_________________

Ordering Physician:______________________________**Credentials:** __________________
Address: ____
City:_______________________________**State:**_______________**Zip:**_________________
Phone #: ________________________
Fax: ____________________________

Facility: _________________________________
Facility address: _________________________
Facility phone#: __________________________

DATE OF SERVICE: ________________________
ICD-10: ___________________________________
CPT CODE (5 digit code): please enter number of sessions desired for each CPT requested:
CPT: (_______) x ( ) sessions starting date ( ) to ending date ( )
CPT: (_______) x ( ) sessions starting date ( ) to ending date ( )
CPT: (_______) x ( ) sessions starting date ( ) to ending date ( )

FOR PT/OT/ST/ABA
How many visits has patient used? ____________
Prior case # on file: __________________________

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