

Prior Authorization Requests

Patient name: _____ DOB: _____

ID#: _____ Group: _____

Insured name: _____

Provider name: _____ Provider phone: _____

Contact name: _____ Provider fax: _____

CPT: _____

Diagnosis Codes: _____

Include:

- All medical records including actual office notes & treatment history.
- All applicable lab reports.
- All applicable radiology reports
- Indicate other providers names & contact information who have been involved in diagnosis & treatment for same diagnosis.

Send this completed form & all supporting documentation to Ellis Consultants, Inc. via fax to 713 592-6112 or email to ccr@ellisconsultants.com.

*With respect to scheduling services, please allow 2 weeks from the date Ellis Consultants receives complete documentation for a final determination.