Prior Authorization Requests

Patient name: _____ DOB: _____

ID#: _____ Group:_____

Insured name: _____

Provider name: _____ Provider phone:_____

Contact name: _____ Provider fax: _____

Diagnosis Codes: _____

CPT 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.

Please note that all benefits for approved expenses will be considered at the lower of a) the network's provider discounted price, b) the maximum the patient is required to pay, c) the result of an objective and independent valuation study performed by an outside reviewer approved by the Plan Administrator or d) 200% Medicare approved amount for the services performed, or e) for drugs, 110% of the Average Sales Price (ASP).

Please sign below that this benefit is acknowledged and that the patient will only be billed for copays, deductibles and co-insurance costs.

_____ _____

Name of Representative **Date**

*With respect to scheduling services, allow a minimum of 2 weeks for the review process once complete documentation is received by the consultant.

Send this completed form & all supporting documentation to 713 592-6112.