

Request for Preservice Review
 Phone: 1-866-902-1689
 Fax: 1-800-823-5520

Date Request Submitted: _____
 Member Name: _____ Date of Birth: _____ Age: _____
 Certificate Number: _____ Sex: Male Female
 Address: _____ City: _____
 State: _____ ZIP Code: _____ Phone: _____

Requesting Physician Name: _____ License Number: _____
 Tax ID Number: _____ NPI: _____
 Address: _____ City: _____
 State: _____ ZIP Code: _____ Phone: _____

Person Completing Form: _____ Phone: _____ Fax: _____

Check One: Medical Surgical Check One: Inpatient Outpatient

Date of Service, if known: _____

Diagnosis: _____ ICD-9: _____

Procedure: _____ CPT/HCPCS: _____

Facility: _____

Service Provider: _____ Tax ID/Medicare ID: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Phone Number: _____

In Network: Yes No

History/Treatment Provided by Referring Physician:

Certain requests for services require specific clinical information for us to authorize requested services. The toolkit has a variety of forms that will help you identify and provide the specific information we need to authorize a service. Always include this information with the Request for Preservice Review form. If there's no form available for the clinical service you are requesting authorization for, please submit clinical information from your own files that would support the request. Thank you.

Health Plan Use Only		
Status		
Approved: _____	Expires: _____	Authorization Number: _____
Comments: _____		
Representative Name _____	Nurse Reviewer: _____	
<p>This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.</p>		