



PRE-AUTHORIZATION REQUEST FORM

Phone: 972-404-8133 or 888-645-1200
Fax: 972-991-5572 or 888-275-9946

Employee is participant in Certified Network?
 YES NO

URA Request: A Requesting Medical Provider must submit the appropriate requested treatment with appropriate clinical notes with submission at the time of the request.

PATIENT INFORMATION PROVIDER INFORMATION

Name: _____
Address: _____

Phone Number: _____
D.O.B. _____
D.O.I. _____
S.S.N. _____

Employer: _____
Insurance Company: _____
Adjuster: _____
Claim Number: _____

Requesting Physician _____
(Physician Requesting Service)
Specialty: _____
Address: _____

Phone Number: _____
Fax Number: _____
Email Address: _____
(For Determination Letters)
Tax ID #: _____
Contact: _____

Peer to Peer Contact Name: _____
Phone: _____

Treating Physician: _____
(Doctor approved by Network or DWC to treat)
Specialty: _____
Address: _____

Phone Number: _____
Fax Number: _____
Email Address: _____
(For Determination Letters)

Tax ID #: _____
Contact: _____
Dates of Service: _____
Inpatient # of Days
Outpatient

Requested Procedure: _____

Frequency/Duration: _____
ICD-9 CODE(S): _____

CPT CODE(S): _____

Please include all supporting clinical documentation to validate this request.

FACILITY INFORMATION (Place of Service)

Name: _____
Address: _____

Phone Number: _____
Fax Number: _____
Email Address: _____
(For Determination Letters)

Specialty: _____
Tax ID #: _____
Contact: _____

IMO USE ONLY:

Date Received: _____ Case#: _____ Preauth#: _____
Due: _____ Notified (Name): _____ Date: _____

Attach the medical documentation including testing reports, medical notes and anything else you think show the medical necessity of the services requested