



PRE-AUTHORIZATION REQUEST FORM

Phone: 713-339-1268 or 877-789-0041
Fax: 713-974-1962 or 877-974-1962

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
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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)

Please include all supporting clinical documentation to validate this request.
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FACILITY INFORMATION <i>(Place of Service)</i>
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Name: _____
Address: _____

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

Specialty: _____
Tax ID #: _____
Contact: _____

Tax ID #: _____
Contact: _____
Dates of Service: _____

Inpatient	# of Days
_____	_____
Outpatient	_____

Requested Procedure: _____

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

CPT CODE(S): _____

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