

Pre-authorization Referral Form

Member Name:	Member ID #:
Referred by (Provider Name):	Referred to (Provider Name):
Referred by (Provider Phone #):	Referred to (Provider Phone #):
Referred by (Provider Fax #):	Referred to (Provider Fax #):
Referred by (Provider ID #):	Referred to (Provider ID #):
Date of request: ____/____/____ Month Day Year	
Diagnosis:	Diagnosis Codes:
Requested Service:	CPT/HCPCS Codes::

Supportive Clinical Information

Related Sign and Symptoms (specify duration of Sx.):

Treatment (specify doses, frequency):

Current Treatment:

Past Treatment:

Related Studies and Findings:

Physician Signature: _____. The information contained in this form is privileged and confidential and is only for use by the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Medical Management Response

() Approved as requested: Authorization Number: _____

of Visits Authorized:: _____

() Not Approved as Requested: ☐ Additional Information Needed (see attached letter) ☐ No Referral Needed ☐ Criteria Not Met

Comments:

Signature: _____ Date: ____/____/____
Month Day Year**ALL AUTHORIZATIONS ARE VALID FOR 90 DAYS FROM THE DATE OF AUTHORIZATION**