Pre-Authorization Request Form

Patient Information

Full Name

Date of Birth

Member ID

Address

Phone Number

Email

Provider Information

Provider Name

Phone Number

Fax Number

Address

Service/Procedure Details

Date of Service

CPT/HCPCS Code

Diagnosis Code (ICD-10)

Procedure Description

Medical Necessity/Justification

Insurance Information

Insurance Company

Policy Number

Group Number

Signature

Date