



Medical Management

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Chart notes and all diagnostic results MUST be attached.

****PLEASE VERIFY ELIGIBILITY AT TIME OF SERVICE****

Patient Name: _____ Date: _____

Member ID#: _____ DOB: _____ City _____ Phone #: _____

Referring Provider: name, address, phone & fax number		Request Provider or facility: address, phone & fax number	
Physician Signature		Office Contact: name, number	
Diagnosis:	ICD-9 Code:	CPT Code:	

Outpatient ()		Outpatient Surgery ()		Inpatient () _____ Day(s)		
Consult Only	Consult & 2 FU's	Visits Used _____	Add FU(s) to Control No. _____	Extended Date		
Allergy	Audiology	Cardiology	Dermatology	Diagnostic	DME	ENT
Endocrinology	Gastroenterology	Infertility	Nephrology	Neurology	Neurosurgery	Oncology
Ophthalmology	Orthopedic	Pain Mgmt	PT/OT/ST	Podiatry	Pulmonary	Radiology
OB/Gynecology	Rheumatology	Sleep Study	Surgery	Urology	Vascular	VNA

Procedure _____

__Added CPT Codes/ FU __Chart Notes __Direct Referral __Medical Review

__Member Terminated __Non-Covered Service __Redirected

Comments _____

Approved _____
 Date

Denied _____
 Date

Pending _____
 Date

Authorized Signature	Control Number
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 AUTHORIZATION IS VALID FOR 90 DAYS FROM APPROVAL DATE**