AULTCARE PREAUTHORIZATION AND REFERRAL FORM

Uploading additional clinical documentation **Yes** **No** **Priority:**

PREAUTHORIZATION NEEDS TO BE RECEIVED BEFORE THE REFERRAL APPOINTMENT!

ALL FIELDS ARE MANDATORY AND REQUIRE COMPLETION FOR PROCESSING

Patient Information **Today's Date:**

Last Name: **First Name:** **Date of Birth:**

Group Number: **I.D.Number:**

Out-Of-Network specialist/facility:

Full Name: **Diagnosis:**

Tax ID: **ICD-10:**

NPI: **Procedure:**

Specialty: **CPT:**

Address:

Telephone: **Fax:**

****Please include office/visit notes that will provide additional history relative to this referral****

Date **Physician requesting referral (please print full name)** **Phone Number** **Fax Number**

Address of Requesting Physician **Tax ID** **NPI**

Physician's Signature **Are you the Primary Care Office?** **Yes** **No** **Person completing this form**

Service Requested: **Office Visit** **Inpatient** **Outpatient** **Ambulatory Surgery** **Other**

Consulatation and Evaluation / Date of Service (if known):

Second Opinion / Date of Service (if known):

Treatment / Procedure / Test: (Specify Code)

Patient Requested Specialist - Specialist and/or Out-of-Network Visit Not Necessary

****An updated plan of care and progress notes must be submitted with request for continued services****

Note: A preauthorization does not guarantee payment or authorize coverage for services not covered through the member's benefit plan. Claims are subject to review upon receipt of the claim/documentation.

Reviewed: 11/02; 1/05; 4/06; 4/07; 5/10; 6/11; 3/13; 5/14; 3/15; 5/20