Covenant MSO
EMPLOYEE BENEFIT PLAN

Referral Type
□ Routine (Process in 48 hours)
□ Urgent (Process in 24 hours)

AUTHORIZATION REQUEST FORM

DATE: _____

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: _____

PRIMARY INSURANCE: _____ SUBSCRIBER ID: _____

WORK RELATED □ YES □ NO **AUTO ACCIDENT** □ YES □ NO **POSSIBLE COB** □ YES □ NO
IF YES, PLEASE EXPLAIN: _____

_____

REFERRAL FROM:

REQUESTED BY (PHYSICIAN): _____

CONTACT PERSON AT PHYSICIAN'S OFFICE: _____

PHONE #: _____FAX #: _____

PCP IF NOT REFERRING PHYSICIAN: _____

REFERRAL TO/FOR:

PHYSICIAN: _____ SPECIALTY: _____

FACILITY / PLACE OF SERVICE: _____ DATE OF SERVICE: _____

MEDICAL INFORMATION:

DIAGNOSIS (DX): _____ DIAGNOSIS CODE(S): _____

CURRENT PROCEDURE CODE(S) / CPT: _____

REASON FOR REFERRAL: _____

_____

Please fax clinical notes along with this form.

UM PHONE #: (512) 806-0162 or (855) 397-3215 **UM FAX #: (877) 300-3764 or (877) 938-2079**