



**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.**

THIS AUTHORIZATION IS NOT A GUARANTEE THAT SERVICES WILL BE COVERED OR THAT PAYMENT WILL BE MADE. ALL MEDICAL SERVICES RENDERED ARE SUBJECT TO CLAIMS REVIEW, WHICH INCLUDES BUT IS NOT LIMITED TO DETERMINATION OF ELIGIBILITY IN ACCORDANCE WITH THE TERMS OF THE MEMBERS BENEFIT PLAN, ANY DEDUCTIBLES, CO-PAYMENTS AND CUSTOMARY CHARGES AND POLICY MAXIMUMS.

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**UM PHONE #: (512) 806-0162 or (855) 397-3215**

**UM FAX #: (877) 300-3764 or (877) 938-2079**