

Prior Authorization Request Form

Fax request form to Care to Care at 1-888-248-4884.

PLEASE PRINT CLEARLY.



Date request received: _____

Date request submitted:		Office contact person:	
Referring physician (First/Last name):		Physician specialty:	
Physician phone #:		Physician fax:	
Facility and location for procedure:			<input type="checkbox"/> MVA (No Fault)
Patient's name:		Date of birth:	
Health plan name:		Patient phone #:	
Member ID#:		State:	

List procedure(s) ordered

Procedures	CPT code if available

Clinical Indications for the ordered exams (e.g. signs, symptoms with severity and duration, working diagnosis)

THIS SECTION MAY BE ACCOMPANIED OR REPLACED BY A COPY MEDICAL NOTES AND/OR REPORTS OF RELEVANT IMAGING AND LAB STUDIES SUPPORTING THE MEDICAL NECESSITY FOR THE STUDY REQUESTED.	ICD-9 if available

Any relevant prior tests, treatments, or other information

If our Physician Reviewer needs to contact the ordering physician what is the best day, time and phone number?

Days (circle):	S M T W Th F S	Times:		Phone:	
Requested by (print):				Submission date:	

Signature:

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