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| **Date of Request** |  |
| **IPA or Medical Group** |  | **Phone No.** |  |
| **Primary Care Provider’s (PCP) Name** |  |
| **Phone No.** |  | **Fax No.** |  |
| **Requesting Provider’s Name** |  |
| **Phone No.** |  | **Fax No.** |  |
| **Other Insurance** |  |
| **Member Name** |  | **Member ID** |  |
| **Phone No.** |  | **DOB** |  | **Gender** | ❑ M ❑ F |
| **Address** |  |
| **City** |  | **State** |  | **Zip Code** |  |
| **Referred to (Physician Name)** |  | **Specialty** |  |
| **Phone Number**  |  | **Fax No.**  |  |  |
| **Primary Diagnosis** |  | **ICD-10 Code** |  |
| **Secondary Diagnosis** |  | **ICD-10 Code** |  |
| **When was the diagnosis first made?** |  |
| **How many times has the patient been seen by the Specialist in the past year?** |  |

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| **PRACTITIONER TREATMENT PLAN****(Please attach or complete this table.)** |
| **# of Visits per** **3 Months** | **# of Visits** **per 6 Months** | **# of Visits** **per 9 Months** | **# of Visits** **per 12 Months** |
|  |  |  |  |

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| **Briefly describe what is anticipated from each visit:** |
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| **IMPORTANT** |
| * Additional information regarding the treatment plan may be requested from the Specialist, if necessary. If so, decision will be made within three (3) business days of receipt of the information.
* Authorization remains valid only if the Member is eligible.
* Payment is contingent upon the Member’s eligibility at the time the service was rendered.
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