

Date Extension Request Form

eviCore healthcare

FAX (800) 599-8350

Date of this Request

___/___/___

INSURED

Patient Last Name	Patient First Name	M.I.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth (MM/DD/YYYY) ___/___/___
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Phone (area code first)
Patient Address		City		State	Zip Code

PAYOR

Employer Name	Insurance Company	Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card)			
Injury or illness is related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Does the patient have other insurance that might cover this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If applicable, other carrier's name:			

DOCTOR

Doctor Last Name	Doctor First Name	M.I.	Area Code + Phone ()	Area Code + Fax ()	
Doctor Address		City	State	Zip Code	Doctor License #

TX PLAN

Authorization Reference No.	Dates Previously Authorized (MM/DD/YYYY) Start Date ___/___/___ End Date ___/___/___	Request to Extend Through (MM/DD/YYYY) ___/___/___ Not to exceed 30 days from the end date previously authorized.
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Submit this date extension request within 30 days of the previously approved treatment plan end date. Otherwise, please submit an updated Treatment Plan form.

I declare that the above information is true and correct to the best of my knowledge.

Signature _____

Date _____