

Avesis Kentucky Medicare Authorization Form

PLEASE FAX FORM TO SECURE FAX:
855-591-3566

MEMBER

MEMBER PLAN ID: _____

TODAY'S DATE: _____

MEMBER LAST NAME: _____

MEMBER FIRST NAME: _____

MEMBER PHONE NUMBER: _____

DATE OF BIRTH: _____

PROVIDER

PROVIDER ID: _____

OFFICE CONTACT: _____

PROVIDER LAST NAME: _____

PROVIDER FIRST NAME: _____

PROVIDER PHONE: _____

FAX NUMBER: _____

FACILITY

Type: OFFICE: _____ OP HOSPITAL: _____ FREE STANDING FACILITY: _____

FACILITY NAME: _____

FACILITY ADDRESS: _____

FACILITY CITY & STATE: _____

FACILITY PHONE: _____ FACILITY FAX: _____

PROCEDURE

PLANNED DATE OF SERVICE (IF AVAILABLE): _____

PRIMARY ICD-9 CODE(S): _____ DESCRIPTION: _____

Description	Old Patient Rx (Right Eye)	Old Patient Rx (Left Eye)	New Patient Rx (Right Eye)	New Patient Rx (Left Eye)	CPT/HCPCS	Units

Pertinant clinical summary (Attach supporting clinical records): _____

FOR OFFICE USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE

APPROVED: _____ DENIED: _____ AUTHORIZATION NUMBER: _____

EFFECTIVE DATE: _____ END DATE: _____

REVIEWING CONSULTANT SIGNATURE _____ DATE SIGNED _____

This document is a determination of a request for authorization to perform services that require prior approval and in no way guarantees or implies that payment will be made. Payment is contingent upon the Member's benefit eligibility on the date the approved services are rendered as well as other factors. Avesis will not consider request for authorization if clinical information is not attached.