



Referral/Pre-Authorization Form

Phone# 800-207-1018

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Referrals (Physicians to Physician)

Pre-Authorization (Services)

***** **CLINICAL notes required for Pre- authorizations** *****

Patient Name _____ DOB _____ Member ID _____

PCP/Referring Physician (Please Print)

Date of request

Referred Provider

Referred Facility

Diagnosis

ICD10

Services Requested

CPT/ HCPC Codes

Surgery requests: Date of Service: _____ Inpatient _____ Outpatient _____

Physician Signature _____ Date _____

Contact person: _____ Telephone # _____

For administration documentation only:

APPROVED: UM# _____ DENIED: _____ PENDED: _____

Comments: _____

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