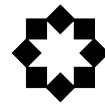


CARELINK PRE-AUTHORIZATION FORM**University
Health System****AUTHORIZATION FAX #: 210-702-4203
PHONE #: 210-358-3224****TODAY'S DATE:** _____**PATIENT'S NAME:** _____**MRN#:** _____**DOB:** _____

PROVIDERS: Payment for services requiring pre-authorization is contingent upon verification of current eligibility and applicable contract specifications at the time of services. Failure to obtain pre-authorization in advance of the service being rendered will result in an administrative denial of the claim. Please allow two business days for processing. Incomplete requests may require additional time for review.

PRE-AUTH SERVICES REQUESTED: (CIRCLE ONE)	23 HRS OBSERVATION	ELECTIVE ADMISSION	SLEEP STUDY
	SURGERY IN-PT	SURGERY OUT-PT	ENDOSCOPY
	HOME HEALTH	OTHER (PLEASE SPECIFY): _____	

COMPLETELY FILL OUT ALL BLANKS FOR APPROPRIATE REVIEW**REQUESTING PHYSICIAN:** _____ **PHYSICIAN ID#:** _____**OFFICE OR DEPT PHONE #:** _____ **DEPT FAX #:** _____ **CONTACT PERSON:** _____**DIAGNOSIS:** _____ **ICD-10:** _____ **DIAGNOSIS:** _____ **ICD-10:** _____**DATE OF SERVICE:** _____ **LOCATION OF SERVICE (S) TO BE RENDERED (CIRCLE ONE):** UH RBG TDI NORTH
UFHC-SE UFHC-SW CHCS Restoration**PROCEDURE:** _____ **CPT-4:** _____ **PROCEDURE:** _____ **CPT-4:** _____**MEDICAL JUSTIFICATION (REASON):** _____

_____**DO NOT WRITE BELOW THIS BOX. FOR CARELINK USE ONLY.****DATE REQUEST REC'D:** _____☐ **APPROVED** **AUTHORIZATION NUMBER:** _____ **START DOS:** _____ **END DOS:** _____☐ **PENDING** **REASON:** _____
_____☐ **DENIED** **REASON:** _____
_____☐ **OTHER** _____
_____**AUTHORIZATION NURSE NAME:** _____ **DATE:** _____