Inpatient Services Preauthorization Form

*Please complete **ALL** information requested on this form. Incomplete forms will be returned to sender.*
Please fax this form along with all pertinent patient medical records to:

Fax to - (859) 253-0099 Attn: Pre-Certification Team

If the request is urgent, please call (877) 309-2955 option 2.

ADMISSION TYPE : *circle one*					
Emergency Admit			Elective Admit:		
Date of Admit:			Anticipated Date of Admit:		
Estimated Date of Discharge:			Estimated Date of Discharge:		
SUBSCRIBER AND PATIENT INFORMATION					
Subscriber Last Name, First:			Subscriber ID:		Group #:
Patient Last Name, First:			Date of Birth:		Sex:
Address:	City:	State:	Zip:	Relationship to Subscriber:	
Other Health Insurance: YES or No	Policy #:		Carrier:		
REQUESTING PROVIDER INFORMATION					
Provider Last Name, First:			Facility:		
Phone:			Fax:		
Address:	City:		State:		Zip:
Tax ID#:			NPI #:		
SERVICING PROVIDER INFORMATION					
Provider Last Name, First:			Facility:		
Phone:			Fax:		
Address:	City:		State:		Zip:
Tax ID#:			NPI #:		
SERVICING FACILITY INFORMATION					
Name:	Phone:		Fax:		
Address:	City:		State:		Zip:
NPI:			Tax ID:		
PROCEDURE INFORMATION					
Date of Procedure:	CPT Code:		Description:		
Units:	Frequency: / week				
Date of Procedure:	CPT Code:		Description:		
Units:	Frequency: / week				
CLINICAL INFORMATION					
Diagnosis Code:	Description:				
Diagnosis Code:	Description:				
Diagnosis Code:	Description:				
Has the patient received treatment for related diagnoses? YES or NO					
List any relevant testing:					
Is this injury related? YES or NO	Date/injury type:				
Submitted by:			Date Submitted:		

Signature of Requesting Provider: _____

Name and Title of Person Completing this Form: _____

Phone Number: _____ **Fax Number:** _____ **Date:** _____