Outpatient 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.

SUBSCRIBER AND PATIENT INFORMATION			
Subscriber Last Name, First:		Subscriber ID:	Group #:
Patient Last Name, First:		Date of Birth:	Sex:
Address:	City:	State:	Zip:
Other Health Insurance: YES or NO	Carrier:		Policy #:
REQUESTING PROVIDER INFORMATION			
Last Name, First:		Phone:	Fax:
Address:	City:	State:	Zip:
Tax ID:		NPI:	
ATTENDING PROVIDER INFORMATION (If Different from Requesting Provider)			
Last Name, First:		Phone:	Fax:
Address:	City:	State:	Zip:
Tax ID:		NPI:	
FACILITY INFORMATION			
Name:		Phone:	Fax:
Address:	City:	State:	Zip:
Tax ID:		NPI:	
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 patient received treatment for related diagnoses? YES or NO			
List any relevant testing:			
Is this injury related? YES or NO	Date/type of Injury:		
Submitted by:			Date Submitted:

Signature of Requesting Provider: ____

Name and Title of Person Completing this Form: ____

Phone Number: ____________________ **Fax Number:** ________________________ **Date:** _____________