PREAUTHORIZATION/ADMISSION FORM

Orders must be faxed to appropriate department. History and Physicals are required on all invasive procedures with conscious sedation**. If you have any questions please call 800-123-4567.**

PATIENT INFORMATION

Patient Name: _____ SSN: _____DOB:_____

PROVIDER INFORMATION

Policy Holder's Name: _____ SSN: _____

Policy Holder's Employer: _____ Employer's Phone Number: _____

Name of Health Plan: _____ Health Plan Phone Number: _____

Policy/ID #: _____ Group #: _____

PYSICIAN INFORMATION

Physician Contact Person: _____ Coordinator's Phone Number_____

FAX Number: _____ Primary Care Physician: _____

Requesting Physician: _____ Requesting Physician's Phone Number: _____

PROCEDURE INFORMATION

Procedure: _____ CPT Code:_____

Diagnosis: _____
Department(s) Involved (Please check all appropriate areas).

OR_____ GI_____ RAD_____ Cath_____ CP _____ Women's Center_____ Day Surgery_____

Date of Procedure:_____ Authorized by: _____
Physician's Authorization Number: _____ Expiration Date: _____
Hospital Authorization Number: _____ Expiration Date: _____
Inpatient: _____ Outpatient: _____ Approximate Length of Stay: _____

Comments: _____
_____
_____
_____
_____