

# REQUEST FOR PREAUTHORIZATION OF MEDICAL TREATMENT

**The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act.**

Employee's Name _____			Requesting Provider _____		Telephone Number ( ) _____	
Address _____			Provider Billing Address _____		City State Zip _____	
City _____		State _____		Zip _____		Tax ID _____
Home Telephone ( ) _____		Work Telephone ( ) _____		Form Prepared By _____		
Social Security Number _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / / _____		Telephone Number ( ) _____	
				Fax Number ( ) _____		

1. The health care provider above requests preauthorization for the following surgery or inpatient admission and all pertinent clinical documentation regarding this request is attached.

Diagnosis: _____	Facility/Place of Service: _____
Setting: _____	Address: _____
Outpatient or Inpatient	Phone & Fax: _____ / _____
Diagnosis Code _____	Tax ID: _____
ICD-9:: _____	Billing Contact: _____
Principal CPT _____	
Code: _____	

2. Requested Service (include description, including body part(s)):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Frequency and Date(s) of Service (include date or length of service and admission date for inpatient treatment):  
\_\_\_\_\_  
\_\_\_\_\_

4. To be completed by Insurer: Procedure/Admission is  Authorized.(or)  Denied upon initial review. (Attach any explanation for decision or state additional information needed.) Insurer determinations shall be sent to all interested medical providers.

Date Completed: _____	Company Name: _____
Signed By: _____	Official Title: _____
Print Name: _____	Preauthorization Number: _____

This form shall be transmitted by the health care provider to the insurer at the e-mail address or fax number designated in the insurer's preauthorization review policy:

**CLAIMS ADJUSTER OR DESIGNATED PREAUTHORIZATION AGENT:** \_\_\_\_\_

**FAX NUMBER:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**REQUEST FOR PREAUTHORIZATION OF MEDICAL TREATMENT (CONTINUED)**

**PROVIDER TO COMPLETE THIS PAGE TO APPEAL INITIAL DENIAL OF REQUEST.**

Review Professional \_\_\_\_\_ Requesting Provider \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_  
Address \_\_\_\_\_ Provider Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tax ID \_\_\_\_\_  
Email Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ Form Prepared By \_\_\_\_\_  
Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

1. Professional Qualifications and Areas of Specialty and State(s) of Licensure of Review Professional:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Review Findings and Determination (G.S. 97-25.3(a)(4)):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Procedure is  Authorized (or)  Denied. (Complete 2 above and attach any further explanation for decision or state additional information needed.) Insurer determinations shall be sent to all interested medical providers.

Date Completed: \_\_\_\_\_ Peer To Peer Conducted?  YES  NO \_\_\_\_\_  
Signed By: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Precertification Number \_\_\_\_\_

This form shall be transmitted by the health care provider to the insurer at the e-mail address or fax number designated in the insurer's preauthorization review policy:

**CLAIMS ADJUSTER OR DESIGNATED PREAUTHORIZATION AGENT:** \_\_\_\_\_  
**FAX NUMBER:** \_\_\_\_\_  
**EMAIL:** \_\_\_\_\_