Clear Form

Goshen Hospital

Pre-Authorization Form

Please Fax completed form to Patient Access 574-364-2410

Today's Date: _____

Patient: _____ **DOB:** _____

Ordering Physician: _____

Physician Rep: _____

Procedure: _____

Date of Procedure: _____ **CPT Code:** _____

W/ Contrast ☐ **W/O Contrast** ☐ **W/WO Contrast** ☐

Insurance Phone # _____ Date Called: _____ Time: _____

Insurance: _____ **Insurance Rep:** _____

Authorization # _____

Call Reference # _____

Insurance Company Authorized for (PLEASE CHECK BOX)

☐ **Inpatient (IN)** ☐ **Outpatient** ☐ **Surgical (DS/SDC)**

# of days approved: _____

Auth Date: _____ **Expiration Date:** _____

*__BOLD__ fields are REQUIRED when applicable

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