Pre-Authorization Form

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

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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