

Texas Association of Counties
P.O. Box 160120, Austin, TX 78716
Preauthorization Hotline (888-580-6805) or Fax (888) 853-8755

REQUEST FOR PREAUTHORIZATION (WC)

Pre-certification is not a guarantee for payment. Please contact health plan to verify member eligibility and benefits.

DATE: _____ **SUBMITTED BY:** Treating Physician Referral Physician Facility

CARRIER CLAIM#: _____ INITIAL REQUEST RECONSIDERATION

CLAIMANT: First Name: _____ Last Name: _____

Mailing Address: _____ City/State/Zip: _____

SS#: ____/____/____ DOB: ____/____/____ DOI: _____

ORDERING PHYSICIAN (if referred) FULL NAME: _____ Specialty _____

Phone Number: (____) ____ - _____ Fax Number: (____) ____ - _____

City/State: _____ Office Contact: _____

TREATING PHYSICIAN FULL NAME: _____ Specialty: _____

Phone Number: (____) ____ - _____ Fax Number: (____) ____ - _____

City/State: _____ Office Contact: _____

TREATMENT LOCATION: _____

Phone Number: (____) ____ - _____ Fax Number: (____) ____ - _____

TREATMENT REQUESTED: _____

Surgery: Outpt ASC Inpt LOS: _____ Surgery Date: _____

Therapy Frequency/Duration: _____ Prior Completed sessions: _____

CPT CODE(S): _____

DIAGNOSIS: _____ ICD9 CODE(S): _____

**THE ABOVE INFORMATION AND MEDICAL DOCUMENTATION MUST BE SUBMITTED WITH
PREAUTHORIZATION REQUEST TO BE CONSIDERED COMPLETE PER DWC 134.600.**