



**WORKER'S COMPENSATION PREAUTHORIZATION REQUEST FOR HEALTHCARE SERVICES
 FAX COMPLETED FORM TO 888-777-8272**

Date	Claimant Name		Date of Birth		
Address			Date of Injury		
Employer		Claim#	First Responder (Fire, Police, EMS) <input type="checkbox"/> Yes <input type="checkbox"/> No		
REQUESTING PROVIDER OR FACILITY					
Name		Phone	Fax		
Contact Name		NPI Number	Tax ID		
Address		City	State/Zip Code		
ORDERING PHYSICIAN			PLACE OF SERVICE		
Name		Name			
NPI	Tax ID	NPI	Tax ID		
Phone	Fax	Phone	Fax		
Address		Address			
PLANNED SERVICE, PROCEDURE OR DME <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT		Number of Visits	CPT or HCPCS Code	Start Date	End Date
Number of PT or OT visits completed		Number Post-op PT or OT completed			
DME Rental Duration and Price		DME Purchase Price			
Diagnosis Description/Body Area(s)		Diagnosis Code(s)			
Peer to Peer Contact Information		Best day/time	Phone		

**ATTACH CLINICAL DOCUMENTATION AND SIGNED ORDERS
 FAX COMPLETED FORM TO 888-777-8272**

CONFIDENTIALITY NOTICE: The information transmitted is intended only for the person or entity to which it is addressed. It may contain confidential and/or patient-specific privileged medical information. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you received this in error, please contact the sender and permanently delete the original and any copy from your computer or device. Form 2019.06