Pre-Authorization

Facility Name:

Facility Address:

Facility Tax ID:

Facility NPI:

Facility Phone #:

Provider Name:

Provider Address:

Provider Tax ID:

Provider NPI:

Provider Phone #:

Patient's Name:

DOB:

Address:

Phone Number:

Member ID #:

Pre-Authorization is Required/Not Required.

Spoke with: ______________________________

Pre-Auth #: ______________________________

Call Reference #: __________________________

Date & Time: _____________________________

Approved / Denied /Pending (Circle one)

Pre-Authorization

Diagnosis Codes (ICD-10):

Procedure Codes (CPT): G0277 and 99183

G0277 is in 30-minute intervals, patients receive 4 units of G0277 per day.

Number of units requested:

G0277 for ________ units.

99183 for ________ visits.

Dates of service/projected start date:

/projected end date:

Notes:

Form Completed By: __________________________________