envolve
Benefit Options

MEDICAL PRE-AUTHORIZATION REQUEST FORM

☐ **ROUTINE**

☐ **URGENT ***

***A physician with knowledge of the patient's medical condition must determine it a case involving urgent care and that use of non-urgent timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or, based on the physician's opinion, the member would be subjected to severe pain. NOTE: Urgent requests MUST be accompanied by a physician's signature. The signature may appear either on this Pre-Authorization form, on the plan of care or medical record.**

Date_____ Office Contact_____ Phone_____ Fax_____

Attending Physician _____NPI# _____

TIN #_____License #_____Medicaid #_____ Medicare # _____

Patient Name (Last)_____(First)_____(Middle)_____ DOB _____

ID # _____HMO (Plan) _____ Group # _____

Other Insurer (if any)_____

Date of Admit _____ Date of Service _____ IP/OP (Circle One) Anticipated LOS_____

Facility Name & Address _____

Facility Status: PAR ☐ NON-PAR ☐ Reason for Non-Par Request:_____

Diagnosis (must be provided)		**Procedure (must be provided)**		**Circle (appropriate eye(s))**		
ICD _____	Description_____	CPT_____	DESCRIPTION _____	RT	LT	50
ICD _____	Description_____	CPT_____	DESCRIPTION_____	RT	LT	50
ICD _____	Description_____	CPT_____	DESCRIPTION_____	RT	LT	50

Medical Reason for Request _____

Attach additional pages if necessary

Patient's Chief Complaint_____

Signature of Attending Physician: _____ Date:_____

Office Address: _____

PRE CERTIFICATION/AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICE(S) ARE RENDERED.

PLEASE FAX YOUR REQUEST TO: (877) 865-1077 OR MAIL TO:
ENVOLVE VISION, INC., ATTN: UTILIZATION MANAGEMENT, PO BOX 7548, ROCKY MOUNT, NC 27804

If denied, please refer to your Provider Manual or call (800) 465-6972 to be informed of your appeal rights.