

MEDICAL PRE-AUTHORIZATION REQUEST FORM

_____ ROUTINE

_____ URGENT *

*A physician with knowledge of the patient's medical condition must determine if 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.

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