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| **Date of Request** | | | |  | | | | | | | | | | | | |
| **IPA or Medical Group** | | | |  | | | | | | | **Phone No.** | | | |  | |
| **Primary Care Provider’s (PCP) Name** | | | | | | |  | | | | | | | | | |
| **Phone No.** |  | | | | | | | | **Fax No.** | |  | | | | | |
| **Requesting Provider’s Name** | | | | | | |  | | | | | | | | | |
| **Phone No.** |  | | | | | | | | **Fax No.** | |  | | | | | |
| **Other Insurance** | |  | | | | | | | | | | | | | | |
| **Member Name** |  | | | | | | | | | **Member ID** | | |  | | | |
| **Phone No.** |  | | | | | | | **DOB** |  | | | **Gender** | | | | ❑ M ❑ F |
| **Address** |  | | | | | | | | | | | | | | | |
| **City** |  | | | | | | | **State** |  | | **Zip Code** | | | | |  |
| **Referred to (Physician Name)** | | | | |  | | | | | | **Specialty** | | | | |  |
| **Phone Number** |  | | | | | | | | **Fax No.** | |  | | | | |  |
| **Primary Diagnosis** | | |  | | | | | | | | **ICD-10 Code** | | | | |  |
| **Secondary Diagnosis** | | |  | | | | | | | | **ICD-10 Code** | | | | |  |
| **When was the diagnosis first made?** | | | | | |  | | | | | | | | | | |
| **How many times has the patient been seen by the Specialist in the past year?** | | | | | | | | | | | | | |  | | |

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| **PRACTITIONER TREATMENT PLAN**  **(Please attach or complete this table.)** | | | |
| **# of Visits per**  **3 Months** | **# of Visits**  **per 6 Months** | **# of Visits**  **per 9 Months** | **# of Visits**  **per 12 Months** |
|  |  |  |  |

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| **Briefly describe what is anticipated from each visit:** |
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| **IMPORTANT** |
| * Additional information regarding the treatment plan may be requested from the Specialist, if necessary. If so, decision will be made within three (3) business days of receipt of the information. * Authorization remains valid only if the Member is eligible. * Payment is contingent upon the Member’s eligibility at the time the service was rendered. |