

PATIENT'S NAME:

G#:

DOB:

OR ADDRESSOGRAPH OF PT'S NAME & G#

CareLink

University Health System

PRE-AUTHORIZATION FORM

AUTHORIZATION FAX #: 358-3274

PHONE #: 358-3224

PROVIDERS: Payment for services requiring pre-authorization is contingent upon verification of current eligibility and applicable contract specifications at the time of services. Failure to obtain pre-authorization in advance of the service being rendered will result in an administrative denial of the claim. Please allow two business days for processing. Incomplete requests may require additional time for review.

PRE-AUTH SERVICES REQUESTED: (CIRCLE ONE)	ELECTIVE ADMISSION	DIAGNOSTIC TESTS REQUIRING 23 HRS OBSERVATION
	SURGERY IN-PT/OUT PT	SLEEP STUDY
	OTHER: PLEASE SPECIFY _____	

COMPLETELY FILL OUT ALL BLANKS FOR APPROPRIATE REVIEW

TODAY'S DATE: _____ REQUESTING PHYSICIAN: _____ ID#: _____

OFFICE OR DEPT PHONE NUMBER: _____ DEPT FAX #: _____ CONTACT PERSON: _____

DIAGNOSIS: _____ ICD-9: _____ DIAGNOSIS: _____ ICD-9: _____

DATE OF SERVICE: _____ LOCATION OF SERVICE (S) TO BE RENDERED (CIRCLE ONE): UH UHC-D UCCH
UFHC-SE UFHC-SW Patrician Movement

PROCEDURE: _____ CPT-4: _____ PROCEDURE: _____ CPT-4: _____

MEDICAL JUSTIFICATION (REASON): _____

DO NOT WRITE BELOW THIS BOX. FOR CARELINK USE ONLY.

DATE REQUEST REC'D: _____

APPROVED AUTHORIZATION NUMBER: _____ START DOS: _____ LENGTH OF STAY: (# OF VISITS): _____

END DOS: _____

PENDING REASON: _____

DENIED REASON: _____

OTHER _____

AUTHORIZATION NURSE NAME: _____ DATE: _____

CARELINK MEDICAL DIRECTOR'S SIGNATURE: _____ DATE: _____

(FOR DENIALS ONLY)

DISCLAIMER: Please be advised that authorization is based upon the medical information provided. Payment for services rendered is subject to verification of medical information or records, the Member's eligibility on the date of service rendered, and all other contractual provisions of the plan. If services, providers, or dates of services change from these indicated, CareLink must be notified prior to services being rendered.

Rev. 10/07 CL Med. Mgt.

This form is intended for provider use only; it should not be distributed to patients.