PATIENT'S NAME:

MRN#:

DOB:

CareLink

University Health System

PRE-AUTHORIZATION FORM

AUTHORIZATION FAX #: 702-4203

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 **23 HRS OBSERVATION**

SURGERY IN-PT **SURGERY Out-PT**

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 RBG TDI UFHC-SE UFHC-SW CHCS**

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:** _____

LENGTH OF STAY: (# OF VISITS): _____

START DOS: _____ **END DOS:** _____

☐ ***PENDING*** **REASON:** _____

_____

☐ ***DENIED*** **REASON:** _____

_____

☐ ***OTHER*** **REASON:** _____

_____

AUTHORIZATION NURSE NAME: _____ **DATE:** _____

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