Referral Type: **Prior-Authorization Form** □ Routine Curative Medical Management Dept. □ Urgent (Service in next72hrs) Phone: (512) 420-2777 CENTRAL Toll Free Fax: (866) 272-2542 Local Fax: (512) 406-6244 HEALTH * Plan Name Medical Access Program (MAP) TERM DATE: ____ TERM DATE:_ TERM DATE: *Request *Submitted by Date: (Name): *Phone # and Ext *Return Fax # (Include area code): (include area code): *Patient Name: *Group ID Number: *DOB: *Patient's ID Number: *Requesting Provider NPI: or Clinic name: NPI: *Requested Specialist or Service: *Requested *Proposed Date # of visits: of Service: *ICD-10 Codes: *Diagnosis **Description:** *CPT or HCPCS *Description: Codes: *Facility Name (for Outpatient NPI: Services/ASCs): * □ Outpatient ☐ In Office □ DME □ Therapy *Reason for referral (please attach pertinent clinical/progress notes or provide clinical narrative, including duration of problem, types of treatment, physical findings, testing results): Please see records attached Coordination of Benefits (Other Insurance)

TO BE COMPLETED BY CURATIVE MEDICAL MANAGEMENT SERVICES

Authorization
Number:
Authorization
Dates:

☐ YES

□ NO

Date of Injury:

Subscriber

Name and ID #:

*MVA

Name of

Insurance:

Subrogation:

Number of Visits or Services Approved:

*Workman's

Coverage:

Compensation: *Other Insurance

Comments/Questions:

☐ YES

☐ YES

NO

NO

* In order to process request, all required fields with asterisks must be completed.

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