DR NAME

ADDRESS

PRIOR AUTHORIZATION REQUEST FORM

Acct # ____________________ Expected DOS:__________________________

Patient Name: ____

Date of Birth: ____________________________ Insurance Name: ____

Treatment Plan:

Current Dx: ____

Expected CPT codes: ____

Time period: _____________________ to _____________________, # of Visits _________________________________

Additional Comments: ____

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For Billing Office use only

Authorization # ____

Time period: _____________________ to _____________________, # of Visits _________________________________

Authorized Dx: ____

Authorized CPT Code : ____

Insurance Rep Name : ______________________________________, Ref # ___________________________________

Additional Notes : ____

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************Please Include Medical records with this sheet************

Note: **Fax the form 48 hours prior to visit so that we can return back to you with the authorization details 24 hours prior to appointment - Fax # 732-404-1556, Attn: Authorization Dept**