Medical Insurance Phone Preauthorization

Date:_____ Patient Number: _____

Patient: _____

Patient's Date of Birth: _____

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependent

Eligibility Date:_____

Subscriber:_____

Subscriber Date of Birth: _____

Subscriber ID# (SS or ID#): _____

Employer/Group Name:_____

Group Number: _____

Medical Insurance Company:_____

Mailing Address:_____

_____

Phone:_____ Fax: _____

Date of Preauthorization: _____

Contact Person: _____ Extension: _____

Time of Conversation:_____

Preauthorization Number:_____

Covered Beneift? ☐ Yes ☐ No

Percent Covered: _____ %

Deductible: $ _____Has it Been Met? ☐ Yes ☐ No

Are there any special qualifications or restrictions? _____

_____

_____

Covered Only If:

☐ Traumatic Injury

☐ In-Network Provider

☐ Performed by a Specialist

Maximum Allowable Fee $ _____

Are our fees within your fee limiation? ☐ Yes ☐ No

Treatment Needs

Diagnosis (ICD-10-CM Code and Description)	Procedures (CPT/HCPCS Codes and Description)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____