CENTRAL HEALTH

Prior-Authorization Form

Curative Medical Management Dept.

Phone: (512) 420-2777
Toll Free Fax: (866) 272-2542
Local Fax: (512) 406-6244

Referral Type:
□ Routine
□ Urgent (Service in next 72hrs)

* **Plan Name**

☐ **Medical Access Program (MAP)** **TERM DATE:**_____ ☐ **MAP BASIC** **TERM DATE:**_____ ☐ **MAP BASIC Dental-only** **TERM DATE:** _____

***Request Date:**	***Submitted by (Name):**
***Phone # and Ext (Include area code):**	***Return Fax # (include area code):**
***Patient Name:**	
***DOB:**	***Patient's ID Number:** ***Group ID Number:**
***Requesting Provider or Clinic name:**	**NPI:**
***Requested Specialist or Service:**	**NPI:**
***Requested # of visits:**	***Proposed Date of Service:**
***ICD-10 Codes:**	***Diagnosis Description:**
***CPT or HCPCS Codes:**	***Description:**
*Facility Name (for Outpatient Services/ASCs):	**NPI:**

* □ **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)

***Workman's Compensation:**	☐ **YES**	☐ **NO**	***MVA Subrogation:**	☐ **YES**	☐ **NO**	**Date of Injury:**	
***Other Insurance Coverage:**	☐ **YES**	☐ **NO**	**Name of Insurance:**			**Subscriber Name and ID #:**	

TO BE COMPLETED BY CURATIVE MEDICAL MANAGEMENT SERVICES

Authorization Number:	**Authorization Dates:**
Number of Visits or Services Approved:	

Comments/Questions:

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