

PRE-AUTHORIZATION FORM



PROVIDENCE HEALTH & SERVICES
CATHOLIC HEALTH INITIATIVES

Billing Department 1-800-541-7891, Ext. 8131

Special Instructions

1. Complete ALL required sections below.
2. Provide patient's insurance card information or fill out the patient's insurance information.
3. Fax this pre-authorization form to patient's insurance company to start the process. Most insurances require preauthorization for coverage. Questions can be directed to our Billing Department at **1-800-541-7891, Ext. 8131**.

PATIENT'S INSURANCE INFORMATION

(SECTION ONLY REQUIRED IF THE FRONT AND BACK COPY OF THE PATIENT'S INSURANCE CARD IS NOT AVAILABLE)

INSURANCE COMPANY NAME: _____ INSURANCE COMPANY PHONE: _____ INSURANCE COMPANY ID NUMBER: _____ INSURANCE COMPANY GROUP NUMBER: _____

INSURANCE COMPANY ADDRESS: _____ CITY, STATE _____ ZIP _____

PERSONAL INFORMATION

PATIENT'S LAST NAME: _____ PATIENT'S FIRST NAME: _____ Mi. _____ DATE OF BIRTH (MM/DD/YY): _____ PATIENT ZIP CODE: _____ GENDER: FEMALE
 MALE
 UNKNOWN

SPECIFY BELOW ALL TESTS ORDERED [PROVIDE TEST NAME(S) AND TEST CODE(S)] :

Chromosomal Microarray 83891 83892 83898 88386
 Other genetic testing (See PAML Test Directory at www.PAML.com) for specific CPT codes _____ _____ _____ _____

SPECIFY BELOW ALL APPLICABLE ICD9 CODES :

REFERRING INFORMATION

ORDERING PHYSICIAN NAME: _____ INSTITUTION REPRESENTATIVE NAME: _____ POSITION/TITLE: _____

INSTITUTION NAME: _____ EMAIL: _____ PHONE: _____ FAX: _____

CLINICAL INDICATIONS FOR REQUEST

HOW WILL APPROVING THIS REQUEST CHANGE THE COURSE OF TREATMENT?

GOAL OF TREATMENT?

WHAT IS THE CLINICAL JUSTIFICATION FOR THIS REQUEST (IF NOT ADDRESSED ABOVE)?

Chart notes required to evaluate medical necessity of request