

PRIOR AUTHORIZATION REQUEST
FOR SERVICES FORM

PLEASE FAX REQUESTS TO: OUTPATIENT : 615-782-7842
INPATIENT : 615-782-7822

Member's Name: _____ ID#: _____

DOB: _____

Ordering Physician: _____ Person Completing Form: _____

Phone: (____) _____ Fax: (____) _____

<ul style="list-style-type: none">• DX _____ ICD-9 CODE: _____• PROCEDURE _____ _____ CPT CODE(S): _____• DATE OF SERVICE: _____• PLACE OF SERVICE: _____• ATTACH SUPPORTING CLINICAL INFORMATION: _____ _____
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AUTHORIZATION REQUESTS REQUIRE A MINIMUM OF 48 HOURS FOR PROCESSING

(FOR WINDSOR USE ONLY)

Auth No: _____

Services Authorized: _____

Auth Start Date: _____

Auth Expiration Date: _____

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