



Please write clearly or complete on-screen, then print
and return to fax# 505-816-3857 or 866- 589-8253

Preauthorization Request

URGENT (If checked, please provide anticipated date of service below)

Please attach supporting documentation to facilitate your request (e.g., the history & physical, letter of medical necessity, original photographs, etc.) This form must be placed on top of the information you are submitting.

Member/Patient Data:

Identification Number: <i>(Include the three-digit prefix)</i>	Group #
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Member's Name:	Date of Service:
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Patient's Name:	Date of Birth:
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Procedure Codes:

Diagnosis Codes <i>(List primary first)</i>	CPT4/HCPC codes(s) include unit of measure/frequency for supplies & services ICD-9 Codes(s)
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Services Rendered	Please check one of the boxes below: <input type="checkbox"/> Provider Office <input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Inpatient Facility Office or Facility Name: _____ Address: _____ Phone: _____ National Provider Identifier (NPI) Number(s) _____
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Please attach or include any additional supporting clinical information in the space below.

Provider Data:

NPI Number(s)	Today's Date:
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**Physician/Professional
Provider Name**

Address

Contact Person	Phone # Fax #
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