Prosthetic Device Pre-Authorization Request Form

Patient Information

Full Name

Date of Birth

Patient ID / MRN

Phone Number

Insurance Provider

Policy Number

Prescribing Physician Information

Physician Name

NPI Number

Phone Number

Email

Facility Name

Fax Number

Prosthetic Device Details

Type of Device

HCPCS / CPT Code

Laterality

Medical Necessity / Clinical Rationale

Requested Date of Service

Supporting Documentation

List attached documents

Comments / Additional Information