Pre-authorization Request Form for Surgery

Patient Name
Date of Birth
Defined ID (MDN)
Patient ID / MRN
Phone Number
Insurance Provider
Policy Number
Group Number
Physician Name
Physician NPI
Contact Number
Contact Number
Proposed Surgery Name
CDT Codo(o)
CPT Code(s)

Surgery Date

Diagnosis (ICD-10 Code)	
Facility Name	
Clinical Justification/Notes	
Requested by (Staff Name)	
Date	