



Workers' Compensation Preauthorization Request for Healthcare Services

Date	Claimant Name		Date of Birth	
Address			Date of Injury	
Employer		Claim#	First Responder (Fire, Police, EMS) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Requesting Provider or Facility				
Name		Phone	Fax	
Contact Name		NPI Number	Tax ID	
Address		City	State/Zip Code	
Ordering Physician			Place of Service	
Name			Name	
NPI	Tax ID		NPI	Tax ID
Phone	Fax		Phone	Fax
Address			Address	
Planned Service, Procedure or DME			Number of Visits	CPT or HCPCS Code
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient			Start Date	End Date
Number of PT or OT visits completed			Number Post-op PT or OT completed	
DME Rental Duration and Price			DME Purchase Price	
Diagnosis Description/Body Area(s)			Diagnosis Code(s)	
Peer to Peer Contact Information			Best day/time	Phone

Attach clinical documentation and signed orders.

Fax completed form to 888.777.8272

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