

DR NAME
ADDRESS

PRIOR AUTHORIZATION REQUEST FORM

Acct # _____

Expected DOS: _____

Patient Name: _____

Date of Birth: _____ Insurance Name: _____

Treatment Plan:

Current Dx: _____

Expected CPT codes: _____

Time period: _____ to _____, # of Visits _____

Additional Comments: _____

For Billing Office use only

Authorization # _____

Time period: _____ to _____, # of Visits _____

Authorized Dx: _____

Authorized CPT Code : _____

Insurance Rep Name : _____, Ref # _____

Additional Notes : _____

*****Please Include Medical records with this sheet*****

Note: Fax the form 48 hours prior to visit so that we can return back to you with the authorization details 24 hours prior to appointment - Fax # 732-404-1556, Attn: Authorization Dept