

Precertification Messages Request for Facsimile Form

Please complete all fields. Doing so will enable us to reply to you in an efficient and minimal amount of time. In most cases, you should receive a response via facsimile or telephone call within **TWO** business days. If we need to verify information not included on this form, authorization may be delayed.

Please fax authorization request to (410) 781-7661.

Calling from: Dr.'s office Hospital Other (e.g., subscriber, spouse, employee)

Contact Information	
Contact full name:	Date:
Contact telephone number: ()	
Contact fax number (for response):	
Contact participating provider number (under which you will bill claims – Tax I.D.#):	
Patient Information	
Patient identification number:	Group #
Patient full name:	Date of Birth:
Patient's full address:	
Patient telephone number: ()	
Treatment Information	
Date(s) of service or admit date(s):	
Place of service (circle one)	<input type="radio"/> Inpatient <input type="radio"/> Outpatient <input type="radio"/> E/R Admit <input type="radio"/> Office
Admitting/treating physician full name:	Telephone No.: ()
Physician full address:	
Diagnosis code(s) (ICD-9):	
Procedure code(s) (CPT-4):	
Hospital/Facility full name:	
Hospital/Facility full address:	
Hospital/Facility telephone number: ()	
Referral number (if applicable): RE#	Referral issue date:
Authorization number (for internal use only)	
Associate Name:	Completed by:
Date:	Time:
Comments:	