

PRE-AUTHORIZATION REQUEST FORM

We are in receipt of your request for pre-authorization. Please complete the following form and fax directly to Local 804 at (718) 786-6176.

PLEASE SUBMIT A LETTER OF MEDICAL NECESSITY AND A BRIEF CLINICAL SUMMARY ALONG WITH THE SLEEP STUDY TEST RESULTS WITH YOUR REQUEST

Member's name: _____

Member ID #: _____

Patient's name: _____ Date of Birth _____

Provider's name: _____

Address: _____

Tax ID # _____

Phone # _____ Fax # _____

Service rendered- _____ Office / _____ Home / _____ Hospital / _____ Surgery Center

MED/ SURG REQUESTS:

ICD Code	CPT code	Description	Charge

MEDICAL EQUIPMENT:

Length of Necessity _____ Rental or Purchase? _____

ICD Code	CPT code	Description	Charge