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 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
___Inpatient ___ Outpatient

Provider contracted with Blue Cross ___Yes ___No

MED/ SURG REQUESTS: **Date of procedure**_____

ICD Code	CPT code	Description	Charge

MEDICAL EQUIPMENT:
Length of Necessity _____ Rental or Purchase? _____

ICD Code	CPT code	Description	Charge