Insurance Prior Authorization Form

Patient's Name ______________________________ **Date of birth** ________________

Primary Insurance Information:

Name of Insurance Company____

Phone # for Eligibility/Benefits or Member Services ______________________________

Name of Primary Insured ___________________________ Date of Birth ______________

ID # ______________________________ Group # ______________________________

Deductible $ _____________ Copay $ ____________ Co-insurance %_________

Is prior authorization required for in-office diagnostic testing? ______________

Phone number to call regarding prior authorization:

Person spoke to: ____________________ Reference # for call: ________________________

Secondary Insurance Information:

Name of Insurance Company____

Phone # for Eligibility/Benefits or Member Services ______________________________

Name of Primary Insured ___________________________ Date of Birth ______________

ID # ______________________________ Group # ______________________________

Deductible $ _____________ Copay $ ____________ Co-insurance %_________

Is prior authorization required for in-office diagnostic testing? ______________

Person spoke to: ____________________ Reference # for call: ________________________

Information obtained by: _______________________ Date: ______________________