REQUEST FOR PRIOR AUTHORIZATION / MARSHALL ORTHOPAEDICS

304 UNIVERSITY, SUITE 212 MARSHALL, TX 75670-5247 PHONE (903) 935-1151 FAX (903) 935-1151 or 935-2307

DATE OF REQUEST:

MEMBER INFORMATION

MEMBER LAST NAME: MEMBER FIRST NAME:

MEMBER ID: MEMBER DATE OF BIRTH:

PROVIDER TO PERFORM THE SERVICE [SAME AS SUBMITTING / REFERRING PROVIDER]

FAX NUMBER: (903) 935-0077 CONTACT NUMBER: (903) 935-1151

CONTACT NAME /REQUESTOR: TRACY WASHINGTON

PROVIDER ID: PICK FROM DROP DOWN LIST

REQUESTED SERVICE

TYPE OF SERVICE: PICK FROM DROP DOWN LIST PLACE OF SERVICE: PICK FROM DROP DOWN LIST

CLINICAL REVIEW

SERVICE /PROCEDURE DESCRIPTION & CPT CODE:
PICK FROM DROP DOWN LIST
REFERRING DIAGNOSIS CODE:
PICK FROM DROP DOWN LIST
START AND END DATES:

☐ 'X' INDICATES PLAN OF CARE ATTACHED

CONTACT INFORMATION

Fax Numbers : Admissions 888-886-0170 Referrals 800-690-7030 Hotline 800-218-7508

Superior requires that certain services be approved before the service is rendered. Please refer to the SHP website, www.superiorhealthplan,com, for the most current full listing of authorized procedures and services. Note that an authorization is not a guarantee of payment and is subject to utilization management review, benefits, and eligibility.

☐ URGENT REQUEST: By checking this box, I certify that this is an urgent request for medically necessary treatment, which must be treated within 24 hours.

_____

Signature of Requesting Physician [required]

FOR OFFICE USE ONLY

Authorization number : _____ Units: _____

Date[s] authorized: _____