

Prior Authorization Form

 curative		Curative Prior Authorization Form CCM PHONE: 855-414-1089 CCM FAX: 877-942-4448				Referral Type: ☐ Routine (Process in 48 hours) ☐ Concurrent (Process in 24 hours)	
*Request Date:		*Submitted by:			*Phone#:		*Fax:
*Patient Name:							
*DOB:		*Patient's ID Number:					
Patient's Address:			City:		State:		Zip:
*PCP or Requesting Provider:					Req. Provider Federal Tax ID#:		
*Requested Specialist or Service:						*Req. # of visits:	
*Diagnosis & ICD- 10 Codes:			LMP:		EDC:		
For Surgical or Imaging Requests							
*Name of Facility:				*Proposed Date of Service:			
*Description of Procedure & CPT or HCPCS(s) Codes:							
*Reason for referral (please attach pertinent clinical/progress notes or provide clinical narrative, including duration of problem, types of treatment, pertinent physical findings, pertinent testing results):							
Pre-admission diagnostic work-ups, including lab, imaging and/or supporting specialty consultations:							
*Pertinent Medical Records faxed:		☐ YES		☐ NO		☐ NA	
Coordination of Benefits (Other Insurance)							
*Workman's Compensation:	☐ YES	☐ NO	*MVA Subrogation :		☐ YES	☐ NO	Date of Injury:
*Other Insurance Coverage	☐ YES	☐ NO	Name of Insurance:		Subscriber Name and ID #		
To Be Completed By Curative Clinical Care Management Services							
Authorization Number:				Authorization Dates:			
Number of Visits:				Services Approved:			
Comments/Questions:							
* In order to process request all required fields must be completed							
This authorization is not a guarantee that services will be covered or payment will be made. All medical services rendered are subject to review, which includes but is not limited to, determination of eligibility in accordance with the terms of the participant's benefit plan, any deductibles, co-pays, co-insurance percentages, reasonable and customary charges and policy maximums. Notice of Confidentiality: The information contained in this facsimile (fax) is privileged and confidential. It is intended for the individual entity indicated on this referral form. You are hereby notified that any dissemination, distribution, copying, or other use of this information by anyone other than the recipient is unauthorized and strictly prohibited. If you have received this fax in error, please notify the curative ccm department.							