



SELECT

Medical Management

Fax: 574-283-5940 or 800/214-0033

401 E. Colfax, Suite 100 • South Bend, IN 46617

Date: _____

Patient Information

Name: _____

Birthdate: _____

Plan Name: _____

Member ID#: _____

Member PCP: _____

Referring Physician: _____

Phone: _____ Fax: _____

Office Contact Person: _____

Referring Signature: _____

Office Use Only:
Required for Red List Service:

Authorization #: _____

Expiration Date: _____

Total Visits: _____

Authorization for:

- Consultation Only
- Consultation and Treatment

Authorizes Specialist to treat:

- 30 Days _____ visits
- 60 Days _____ visits
- 90 Days _____ visits
- Other _____ visits Expiration Date _____

ICD-9/Code & Description (mandatory): _____

Referred to Specialist or Facility:

Name: _____

Specialty: _____

Address: _____

Phone: _____

Fax: _____

Appt. Date: _____

- MRI (type): _____
Rationale: _____
- Home Care Visits: # of Visits: _____
- Therapy Visits: ___ PT ___ OT ___ Speech ___ Cardiac
- Outpatient
Procedure: _____
CPT: _____
- 23-hour Observation
Procedure: _____
CPT: _____
- Inpatient
Procedure: _____
CPT: _____
- DME: _____
HCPCS: _____

Please answer the following:

Related to MVA? Y N
Related to employment? Y N

Related to other accident? Y N
If yes, give date: _____
Other Insurance Coverage? Y N
If yes, Carrier Name: _____

COMMENTS: