Trusted
SENIOR CARE ADVANTAGE

AUTHORIZATION REQUEST FORM

Fax to (614) 259-0293

Date ____ / ____ / ____

Request Type

☐ **Routine** ☐ **Urgent** ☐ **Retroactive**

Requesting Provider

Requesting Provider Name _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Contact Name _____ Phone (____) ____ _____ Fax (____) ____ _____

Patient Information

Patient ID _____ Date of Birth ____ / ____ / ____

Patient Name _____ Sex ☐ Male ☐ Female

Address _____ Phone (____) ____ _____

City _____ State _____ Zip _____ Best Contact# (____) ____ _____

Carrier Name _____

PCP ID# _____ PCP Effective Date ____ / ____ / ____

Referred To Provider

Service Location ☐ Home ☐ Office ☐ Outpatient Hospital ☐ Ambulatory Surgery ☐ Inpatient ☐ Other

Specialty _____

Provider ID _____ Name _____

Address _____ City _____ State _____ Zip _____

Contact Name _____ Phone (____) ____ _____ Fax (____) ____ _____

Requested Treatment

Diagnosis

_____

_____

_____

Procedures

_____

_____

_____

Clinical Comments