



P.O. Box 1120
Danville, Virginia 24543



PLEASE FAX TO GATEWAY
(434-799-4397)
OR CALL
(434-799-0702)
OUT OF AREA
(877-846-8930 Option 1)

PRE-AUTHORIZATION REQUEST

Date: _____

Date of Service:		Ordering Physician:	
Patient Name:			
Subscriber's Employer:		Subscriber's ID#:	
Specialist/Hospital Referred to:			
Diagnosis/Reason for Referral:		DX Code:	
Clinical Summary (if not included in a referral letter)			
Referral Type			
<input type="checkbox"/> Consultation for diagnosis/treatment if applicable (1 visit only) <input type="checkbox"/> Consultation /treatment with follow up (up to 3 SCP visits within 90 days) <input type="checkbox"/> Extended referral (allergy, dialysis, radiation or chemotherapy, prolonged orthopedic care, burn care, prenatal care, neonatal care, complicated rheumatology or infectious disease care, advanced neuromuscular, other) Duration _____ (up to one year)			
<input type="checkbox"/> Hospital Admission <input type="checkbox"/> OP diagnostic/Services <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Emergency Room <input type="checkbox"/> ELOS _____ Day(S)			
Scope of Services Authorized (N/A for hospital admission)			
Procedures:			

NOTE: This authorization is based on medical necessity and is not a guarantee of payment. Final payment will be based upon the available contractual benefits at the time services are rendered. For benefits and eligibility, please call the number on the back of the member's health plan care.

For PRIMARY PHYSICIANCARE Office Use Only	
Authorization Number: _____	
EFFECTIVE DATES: FROM: _____ TO: _____	
<input type="checkbox"/> PCP	<input type="checkbox"/> SCP <input type="checkbox"/> Facility
Medical Director <input type="checkbox"/> YES	

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