



**PREAUTHORIZATION REQUEST FORM**

**Date of Request:** \_\_\_\_\_

**Date Received:** \_\_\_\_\_

**Phone: (702) 832-4658**

**Fax: (562) 506-0340**

**Email: THTpreauth@tristargroup.net**

We request completion of this form and submission of necessary records to facilitate your request. Thank you

Patient Name:		Health Plan:	
Address:		ID#	
City:	State:	Zip:	Requesting Provider/Physician:
Phone Number:	Date of Birth:	Phone#:	Fax#:
Insured Name:	SS#:	Tax ID#:	Contact person:
<b>Treatment Requested:</b>		<b>Dates of Service:</b>	
<b>Diagnosis:</b>		<b>ICD-9/10 Codes:</b>	
<b>CPT Codes:</b>		<b>Frequency/Duration:</b>	
Initial Request ROUTINE ( ) <b>STAT-MEDICALLY URGENT</b> ( ) 2nd Request ( ) Reconsideration ( )			
Request Provider/Facility/Location:			
<i>As a reminder, the plan sponsor, Teachers Health Trust requires that you confirm/validate the anesthesiologist(s) is in-network.</i>			
<b>Requesting Physician Signature</b>		Date:	In- Patient or Out- Patient
<b>TMC Authorization Number:</b>		<b>Cert Type:</b> <input type="checkbox"/> Pre-Authorization	
<input type="checkbox"/> Certified	<input type="checkbox"/> Not enough info to approve request	<input type="checkbox"/> Concurrent Review	
<input type="checkbox"/> Out of network	<input type="checkbox"/> Non-Covered Benefit	<input type="checkbox"/> Retrospective	
<input type="checkbox"/> Need addtn'l info	<input type="checkbox"/> Medical information does not meet criteria	<input type="checkbox"/> Serious / Imminent Threat	
<b>Medical Director Decision</b>	<b>Approved request</b> <input type="checkbox"/> <b>Denial</b> <input type="checkbox"/> <b>Withdrawal</b> <input type="checkbox"/>	<b>MD Signature/Date</b>	
<b>Authorization is subject to Eligibility and Benefits. Authorization is not a guarantee of payment.**</b>			

TMC Office Use Only

TMC Authorization Number:	Case Manager Name:
Authorization Date:	Customer #:
Referral Type:	Eligibility Confirmed Date:

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