TRISTAR
MANAGED CARE

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:

Treatment Requested: **Dates of Service:**

Diagnosis: **ICD-9/10 Codes:**

CPT Codes: **Frequency/Duration:**

Initial Request ROUTINE ☐ **STAT-MEDICALLY URGENT** ☐ **2nd Request** ☐ **Reconsideration** ☐

Request Provider/Facility/Location:

As a reminder, the plan sponsor, Teachers Health Trust requires that you confirm/validate the anesthesiologist(s) is in-network.

Requesting Physician Signature	Date:	In- Patient ☐ or Out- Patient ☐

TMC Authorization Number:

Cert Type: ☐ Pre-Authorization

☐ Certified	☐ Not enough info to approve request	☐ Concurrent Review
☐ Out of network	☐ Non-Covered Benefit	☐ Retrospective
☐ Need addtn'l info	☐ Medical information does not meet criteria	☐ Serious / Imminent Threat

Medical Director Decision	**Approved request** ☐ **Denial** ☐ **Withdrawal** ☐	**MD Signature/ Date**	

Authorization is subject to Eligibility and Benefits. Authorization is not a guarantee of payment.**

TMC Office Use Only

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