



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:			
Requesting Physician Signature		Date:	In- Patient or Out- Patient
TMC Authorization Number:		Cert Type: <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	
Medical Director Decision	Approved request <input type="checkbox"/> Denial <input type="checkbox"/> Withdrawal <input type="checkbox"/>	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:

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