TEACHERS HEALTH TRUST
For Teachers By Teachers

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: Performance Plus Plan, Teacher's Health Trust
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: ☐ 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: