TRISTAR
MANAGED CARE

PREAUTHORIZATION REQUEST FORM

Date of Request: _____ **Date Received:**

Phone: (702)-216-8623
Fax: (702)-216-8700 **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: