

Member ID:

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Patient's Name: _____

Principal: _____

Secondary: _____

Complaints Pertinent to Request /Pertinent History/ Objective Findings/Date & Type of Surgery if Related to Request:

Prior Treatment/Medication Therapy & Outcomes:

Prior Diagnostic Studies & Results:

Projected Treatment Plan and Expected Outcome:

Comments:



Name of Ordering/Treating Physician: _____

Physician Signature: _____ Date: ____ / ____ / ____

Physician Specialty: _____ Telephone: (____) ____ - ____

Office Address: _____

Name of Facility/Vendor Providing Service:

Address: _____

Vendor Authorized Signature: _____ Print Name: _____ Title: _____

Contact Person: _____ Title: _____

Telephone: (_____) _____ - _____

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD-9 codes must be included.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446.

Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.