Medical Coverage Determination Form

FAX AUTHORIZATION REQUEST FORM
FOR
COVERAGE DETERMINATIONS

Please utilize this form as an alternative to calling in request(s) or services. This form should be faxed to VNS CHOICE Utilization Management Department at 1(866) 791-2214. Should you have any questions please call 1(866) 791-2215. Thank you for your cooperation.

♦ PATIENT & INSURANCE INFORMATION (PLEASE FILL-IN AVAILABLE) ♦	
Patient's Name	**Patient Address**
ID #	**Date of Birth**
Patient's Home Telephone	**Alternate Telephone**
Other insurance	**Effective Date**
Is this service related to: □ Motor vehicle accident □ Worker's Compensation □ Other	
♦ AUTHORIZATION INFORMATION ♦	
Date of Request	**Service Requested**
Date of onset of service/hospital admission	**Requested length of stay/service**
Diagnosis	**ICD9 Code(s)**
Procedure	**CPT Code(s)**
Comments/medical necessity **In order to expedite your request in a timely manner, please submit copies of all pertinent medical information.**	

♦ PHYSICIAN INFORMATION ♦		
Ordering/Attending Physician Name	**Tax ID**	**Provider's area(s) of subspecialty or expertise.**
Address	**City/State**	**Zip**
Telephone Number	**Fax Number**	
Facility	**Telephone Number**	**Tax ID Number**
Submitted by	**Physician Signature**	

♦ FOR INTERNAL USE ONLY ♦
Authorization Status: □ Approved Authorization #:____________________ **LOS/# Visits: ____________________ Dates of Service:________________**
□ Denied □ Pended **Additional Information ________________ Medical Review________________**

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