carelon

PREAUTHORIZATION/ RQI REQUEST FAX FORM

Instructions:

If Urgent request please call CARELON

Please complete ALL information requested on this form, incomplete forms will be returned to sender.

TO: CARELON MEDICAL BENEFITS MANAGEMENT PREAUTH/RQI DEPARTMENT
www.carelon.com

FAX #: 800-610-0050

FROM: Contact Person	Phone #:	
	Fax #:	

Subscriber (Insurance Holder) and Patient Information

Subscriber Name: **Last:** **First:**	**Patient Name:** **Last :** **First:**
ID #: (include alpha prefix)	**DOB:_____/_____/_____ SEX: M F**
SSN:	**RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD**
Health Plan Name:	
Group #: Product type: PPO POS HMO	
Other:	

Referring Physician Information (The physician who is ordering the exam)	***Provider Information (Where the service will be provided)***
Name: Last: First:	**Name of Facility:**
Phone: (_____)	**Address:**
Fax: (_____)	
Address:	**Phone: (_____)**
Specialty:	

Procedure(s) Information (please include CPT Code, if available)

Date of Procedure: / /	**Procedure:**	**CPT Code:**
Date of Procedure: / /	**Procedure:**	**CPT Code:**
Date of Procedure: / /	**Procedure:**	**CPT Code:**

Clinical Information *(all info must be completed)*

1. Patient's diagnosis or symptoms (include duration, frequency, and intensity) _____
2. What is the physician suspecting or ruling out with the requested study?
3. Has the patient received treatment for the above symptoms (include duration and type)?
4. List any previous relevant testing (i.e. labs, diagnostic imaging, or other test), include results:
5. Is this injury related? Yes _____ No Date and type of Injury:
6. Is study part of a standard post-chemo/radiation protocol in a patient with a prior cancer diagnosis? Yes No
   Cancer type: _____