

Patient Precertifications

Dr: _____

Patient Name: _____ SS#: _____
Date Of Birth: _____ Employer: _____
Ins Co: _____ Phone#: _____
Case Manager (if one is assigned): _____ Insured: _____
Policy # _____ Grp# _____
DX: _____ ICD9: _____

Date: _____ Time: _____ Who You spoke with: _____
Therapy: _____

Approval Dates: _____ Auth#: _____

CPT Codes: _____

Date: _____ Time: _____ Who You spoke with: _____
Changes in Therapy: _____

Approval Dates: _____ Auth#: _____

CPT Codes: _____

Date: _____ Time: _____ Who You spoke with: _____
Changes in Therapy: _____

Approval Dates: _____ Auth#: _____

CPT Codes: _____

Date: _____ Time: _____ Who You spoke with: _____
Changes in Therapy: _____

Approval Dates: _____ Auth#: _____

CPT Codes: _____

