P.O. Box 6905
Canton, OH 44706
Phone: (216) 535-4014
Fax: (330) 363-2350

UNIVERSITY HOSPITAL MEDICARE ADVANTAGE PLAN by PTHP
PREAUTHORIZATION AND REFERRAL FORM

PCP must make initial referral.
PCP or Spec. may extend referrals.

PREAUTHORIZATION NEEDS TO BE RECEIVED BEFORE THE REFERRAL APPOINTMENT!
*****ALL FIELDS ARE MANDATORY AND REQUIRE COMPLETION FOR PROCESSING*****

Patient: ____________________________ Date of Birth _____________ Today's Date: ______________________________

Group Number: _____________________________ I.D. Number: ________________________________

Out Of Network specialist/facility:

Full Name: ____ Diagnosis: _________________________________

Tax ID: ____ ICD-9/ICD-10: ______________________________

NPI: ____ Procedure: ________________________________

Specialty: ____ CPT: ______________________________________

Address: ____

Telephone: ____ Fax: _______________________________________

****Please include office/visit noted that will provide additional history relative to this referral****

____

Date **Physician Requesting Referral (Please print full name)** **Phone Number** **Fax Number**

____

Address of Requesting Physician **Tax ID** **NPI**

____

Physician's Signature **Are you the Primary Care Office? Yes or No** **Person filling out referral**

Service Requested: ☐ **Office Visit** ☐ **Inpatient** ☐ **Outpatient** ☐ **Ambulatory Surgery** ☐ **Other**__________________

_____**Consultation and Evaluation/ Date of Service (if known): Date** _____/_____/_____

_____**Second Opinion / Date of Service (if known): Date** _____/_____/_____

_____**Treatment / Procedure / Test (Specify Code:**____

_____**Patient Requested Specialist – Specialist and/or Out-of-Network Visit Not Necessary**

****An updated plan of care and progress note must be submitted with request for continued services****

Note: A preauthorization does not guarantee payment or authorize coverage for services not covered through the member's benefit plan. Claims are subject to review upon receipt of the claim/documentation.