



MEDICAL MANAGEMENT
P.O. BOX 5750
Springfield, MO 65801-5750
Toll Free # 1-800-205-7665
Local: 417-269-2813
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Medical Services Authorization Form

Today' Date: Form Completed By: Time:

1. PATIENT INFORMATION

Patient's Last Name: First: Middle: DOB: Sex: 11 Digit Insurance ID #:
Male
Female

2. MEDICAL SERVICE REQUESTED

Requesting/Referring Provider: Phone #: Ext. #: Fax #:
( ) - ( ) -

(Please Circle): 1. Outpatient 2. Inpatient 3. Partial

Physician Ambulance DME Home Health Hospice Prosthetics Orthotics Out of Network at In Network
Refer to Case Management Other

Hospital/Facility/or Provider of Service Name: Phone #: Ext. #: Fax #:
( ) - ( ) -

Physical Address (Where Services will be Rendered):

City: State: Zip Code: Tax Id# for Billing:

Admission Date: # of Days Requested: Start Date: End Date: # of Vists or Units:

Diagnosis (ICD9 Code) With Description:

Procedure Code (Provide CPT Code(s) With Description):

Additional Information on Requested Service:

3. FOR COX HEALTHPLANS USE ONLY

Authorization #: Start Date: End Date: Service (s) Authorized:

Additional Comments:

Disclaimer: This authorization is not a guarantee of payment and is subject to final verification of member eligibility and limited to the services specified above. Member is responsible for payment of services received while ineligible for coverage at the time the services were rendered. CHP reserves the right to deny or allow payment on any services based upon the contracted benefits of the member; to retract any authorization if any pre auth information is misrepresented. Payments for services are subject to industry coding standards; Workers Comp investigation and possible exclusion; and pre existing investigation for all PPO plans with a pre existing exclusion.

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