



MEDICAL MANAGEMENT
 P.O. BOX 5750
 Springfield, MO 65801-5750
 Toll Free # 1-800-205-7665
 Local: 417-269-2813
 Fax #:417-269-2919

Please Print or Type Clearly

Medical Authorization Form
Form Must Be Filled Out Completely Prior to CHP Review

Today' Date:	Form Completed By:
---------------------	---------------------------

1. PATIENT INFORMATION

Patient Name	DOB:	Sex:	11-Digit Patient Insurance ID #:
Last : First: Middle:	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	_ _ _ _ _

2. MEDICAL SERVICE REQUESTED

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

(Please Circle):
 ___ 1. Outpatient ___ 2. Inpatient ___ 3. Partial ___ 4. Other : _____

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

Rendering Hospital/Facility/or Provider -*Physical Address (*REQUIRED TO DETERMINE BENEFIT):

City*:	State*:	Zip Code*:	Tax Id# for Billing* (REQUIRED):
Admission Date*:	# of Days/Units Requested:	Start Date:	End Date:
/ /		/ /	/ /

Diagnosis (ICD-9 Code) With Description (REQUIRED): (NOT FOR CLINICAL/MEDICAL RECORDS. ATTACH SEPARATELY.):

Procedure Code (CPT Codes) With Description (REQUIRED):

3. COX HEALTHPLANS USE ONLY

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

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.

Notice of Confidentiality:

The documents accompanying this facsimile transmission contain confidential information that is legally and/or medically privileged and belongs to the sender. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile transmission in error, please notify the sender immediately to arrange for return of these documents.