

~have the physician complete this form so you will have all the necessary information when you call the payer

## PRIOR-AUTHORIZATION REQUEST FORM

**\*\*This form is to be complete by the Prescribing Physician**

Date of Request: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_

Plan #: \_\_\_\_\_

### Physician Information

Physician Name and Specialty: \_\_\_\_\_

Facility Name & Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Provider #

*Office Staff Use Only*

ICD-9-CM Code(s): \_\_\_\_\_

CPT Code: 0084T - Insertion of a temporary prostatic urethral stent