CONNECTED
SENIOR CARE ADVANTAGE

Authorization Request Form

Fax: 512-872-6910

Date: _____

Request Type ☐ Routine ☐ Urgent ☐ Retroactive

Requesting Provider

Requesting Provider Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: (___) ___ - _____ Fax: (___) ___ - _____

Patient Information

Patient ID: _____ Date of Birth: __ / __ / _____

Patient Name: _____ Sex: ◯ Male ◯ Female

Address: _____ Phone: (_____) _____-_____

City: _____ State: _____ Zip: _____ Best Contact #: (_____) _____-_____

Carrier Name: _____

PCP ID#: _____ _____ PCP Effective Date: ____ / ____ / _____

Referred To Provider

Service Location: ☐ Home ☐ Office ☐ Outpatient Hospital ☐ Ambulatory Surgery ☐ Inpatient ☐ Other

Specialty: _____

Provider ID: _____ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: (___) _____ - _____ Fax: (___) _____ - _____

Requested Treatment

Diagnosis:

_____ _____

_____ _____

_____ _____

Procedures:

_____ _____

_____ _____

_____ _____

Clinical Comments: