centrix
BENEFIT ADMINISTRATORS

Representative: _____ Call Reference No. _____

Ph: (800) 585-5965 or (619) 220-9002
P.O. Box 212199, Chula Vista, California 91921

Group: _____

Health Care Authorization Form

SECTION 1

Member Information

Group Name	Subscriber	Date
Patient	Dependent	Member I.D. #

Provider Information

Provider	Contact	Tax I.D.
Specialty	Phone	Date Requested
Procedure	Facility	FHN Verification Obtained? ○ Yes ○ No

Documents Needed

○ 1. Current Clinical Progress Notes	Notes:
○ 2. Requisition Order from Physician including ICD10 and CPT Listing Codes	Notes:
○ 3. Prior Diagnostic Results	Notes:
○ 4. Pricing	Notes:
○ 5. Verification of FHN	Notes:
○ 6. Pre-Certification Completed with American Health Holding	Notes:

SECTION 2

Medical Review

Date Sent	Disposition

Comments

SECTION 3

Formal Notification to Provider

Was Procedure Authorized?	Terms
Was Provider Advised?	Contact

Formal Notification to QVI

Date Advised