Medical Necessity Review/Request for Pre-authorization
Fax to 972-827-1006

WebTPA
A GuideWell Company

Request Date: _____

Review Type: ☐ Admission/Initial ☐ Retrospective ☐ Inpatient ☐ Outpatient

MEMBER INFORMATION

Member Name: Last, First, Middle

_____

Address: _____

_____

_____

Date of Birth: ☐☐/☐☐/☐☐

Member ID #: ☐☐☐☐☐☐☐☐☐☐☐☐

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Sex: ☐ Age: ☐☐☐

Please enter Admission / Start date of Service:

☐☐/☐☐/☐☐

REQUESTOR CONTACT INFORMATION

Requestor's Name: _____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

Place of Service: ☐ Home ☐ Inpatient

☐ Outpatient ☐ Physician Office ☐ Other

Severity: ☐ Standard (non-urgent)

☐ Urgent ☐ Other

REQUESTING PHYSICIAN / PROVIDER

Name: Last, First, Middle _____

Address: _____

_____

Specialty: _____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

TIN #: ☐☐☐☐☐☐☐☐☐
(Required)

NPI #: ☐☐☐☐☐☐☐☐☐☐

FACILITY INFORMATION

Facility: _____

Address: _____

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax # : (☐☐☐) ☐☐☐-☐☐☐☐

TIN #: ☐☐☐☐☐☐☐☐☐

(Required)

DIAGNOSIS / PROCEDURE

Primary Diagnosis: _____

Primary Diagnosis Code: _____

Procedure Code: _____

Description: _____

Start Date: ☐☐/☐☐/☐☐

End Date: ☐☐/☐☐/☐☐

Units: ☐☐☐☐ (Days, Units, Visits) Circle

SUPPORTING DOCUMENTATION:

Type of Review Request	Documentation
All Types of Review Requests	**Please send pertinent clinical information relating to the above request with this form.**
Urgent Review Requests	Requests can only be submitted as urgent ***if applying the standard review time frame may seriously jeopardize the member's life, health, or ability to regain maximum function.***

Disclaimer Statement

A medical necessity determination does not guarantee payment for services. Eligibility for and payment of services are subject to all terms and conditions and limitations of the Summary Plan Description.

Requesting Provider Attestation Statement

I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services have been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

Printed Name: _____

Signature: _____

Date: _____

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