

**PLEASE NOTE:** All services requiring pre-certification (other than on an emergency basis) must be approved in advance by a HMO Medical Director/designee. Pre-certification is subject to all terms and conditions of the Health Service Contract and is only valid for eligible health plan member at time of service.  
5452701

**PROVIDER'S INFORMATION (PROVIDER/FACILITY SUBMITTING AUTH REQUEST)**

DATE OF REQUEST: \_\_\_\_\_ PROVIDER'S NAME: \_\_\_\_\_  
 TPI # \_\_\_\_\_ NPI # \_\_\_\_\_  
 CONTACT PERSON: \_\_\_\_\_ PHONE NO. \_\_\_\_\_ FAX NO. \_\_\_\_\_  
 SERVICE LOCATION: \_\_\_\_\_ MAIL ADDRESS: \_\_\_\_\_

**MEMBER'S INFORMATION**

NAME: \_\_\_\_\_ MEMBER I.D. NO.: \_\_\_\_\_ **SSI** (Circle if SSI)  
 DOB: \_\_\_\_\_ Member Phone: \_\_\_\_\_ PCP: \_\_\_\_\_

**REFER TO INFORMATION (PROVIDER/FACILITY PERFORMING SERVICE IF DIFFERENT FROM ABOVE)**

PROVIDER'S NAME: \_\_\_\_\_ TPI # \_\_\_\_\_ NPI # \_\_\_\_\_  
 CONTACT PERSON: \_\_\_\_\_ PHONE NO. \_\_\_\_\_ FAX NO. \_\_\_\_\_  
 SERVICE LOCATION: \_\_\_\_\_ MAIL ADDRESS: \_\_\_\_\_

**PROCEDURE INFORMATION**

TYPE OF SETTING:  OFFICE VISIT  OFFICE VISIT W/TREATMENT  LABS  RADIOLOGY  
 THERAPY (OT, PT, ST)  SURGICAL  DENTAL  HOME HEALTH  PODIATRY  
 INPATIENT SCHEDULED SERVICES  DIABETES/ASTHMA EDUCATION  OTHER

EXPECTED DATE OF PROCEDURE: \_\_\_\_\_

1.	PRIMARY DIAGNOSIS CODES (ICD-9)	1.	CPT PROCEDURE CODES	SSI ONLY	
				TYPE OF SERVICE	MODIFIER
1.	_____	1.	_____	_____	_____
2.	_____	2.	_____	_____	_____
3.	_____	3.	_____	_____	_____
4.	_____	4.	_____	_____	_____
5.	_____	5.	_____	_____	_____

**PLAN OF TREATMENT/PERTINENT CLINICAL HISTORY AND PHYSICAL EXAM  
(INCLUDE PREVIOUS MEDICAL MANAGEMENT, LAB AND/X-RAY RESULTS):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR EL PASO FIRST USE ONLY**

REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_ APPROVED: YES NO  
**REFERENCE NO.** \_\_\_\_\_