The Everett Clinic
For the whole you.

TEC Delegation Plans Prior Authorization Request Form

DO NOT USE THIS FORM TO REQUEST: Skilled Nursing Facility Admission or Long Term Acute Hospital Admission. Please Call 425-317-3494 and ask for the UM RN.

TEC Care Coordination Contact Information:
Phone: 425 317 3977
Fax: 425 259 1181

Date: ___________________ **Contact Person:** _____________________

Phone number: __________ **Fax Number:** ________________________

To process your prior authorization, we will need the following:

Patients Name: _________________________ **DOB:** ______________________________

Insurance ID number: ____

Name of Servicing Provider & Tax-ID: ____

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Servicing Facility Name & Tax-ID: ____

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CPT Codes along with Quantity of each code: ___________________________________

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ICD10 Codes: ____

Dates of service: ____

*If you are requesting Surgery you need to indicate **Inpatient or Outpatient**

If inpatient the number of days, you are requesting: ______________________________

<u>FOR ALL DURABLE MEDICAL EQUPMENT-</u>

Please supply the individual price per item, and the total price per faxed request: __________

* If the request is for Surgical Procedure/advanced imaging/DME/home health, etc., please submit all relevant clinical data such as progress notes, treatment rendered, tests, lab results, and radiology reports to support the request for services. This will help us process your request without delay.

*Can clinical data be found at Care Everywhere? **Yes No**

If yes, it is **not** necessary to fax clinical data, we have access to Care Everywhere.

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Request is invalid if any of the above information is missing