TEC Delegation Plans Referral/ Prior Authorization Request Form

Phone: 425 317 3977 | Fax: 425 259 1181

Date: _____ **Contact Person:** _____

Phone number: _____ **Fax Number:** _____

In order to process your referral, we will need the following:

Patients Name: _____ **DOB:** _____

Insurance ID number: _____

Servicing provider: _____

Servicing Facility: _____

NPI or TID: _____

CPT Codes along with Quantity of each code: _____

ICD10 Codes: _____

Dates of service: _____

*If you are requesting a Procedure you need to indicate **Inpatient** ☐ **Outpatient** ☐

If inpatient the number of days you are requesting: _____

FOR ALL DURABLE MEDICAL EQUPMENT

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

***** If the request is for Surgical Procedure/advanced imaging/SNF/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.