

# 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: \_\_\_\_\_

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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 EQUIPMENT**

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.

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