Pembroke Center for Wellness

773 Old Main Rd.
Pembroke, NC 28372

AUTHORIZATION REQUEST FORM

DATE:_____

PT NAME &CHART #: _____

AUTH #: _____

NUMBER OF VISITS? _____

DATES OF AUTH? _____

Does the Company offer out of network coverage? YES OR NO

COPAY? $_____ **DEDUCTIBLE?: $_____**

ARE CLAIMS SENT TO A VENDOR (IE MAGELLAN, VALUE OPTIONS,UBH,CBH, DOCTORS DIRECT, ETC) EX: PT MAY HAVE BCBS, BUT MENTAL HEALTH CLAIMS ARE SENT TO VALUE OPTIONS FOR PAYMENT. PLEASE ASK REP THIS QUESTION. ***IS AUTH NEEDED FOR PSYCHOLOGICAL TESTING?!

YES OR NO (CIRCLE ONE)

IF SO WHO: _____

CLAIMS ADDRESS: _____

DOES PT HAVE A DIFFERENT ID NUMBER WITH VENDOR (THIS IS IMPORTANT)? YES OR NO (CIRCLE ONE)

IF SO WHAT IS IT? _____

PLEASE SEND THIS SHEET TO BILLING WITH CHART, FILE A COPY IN THE CHART AND ENTER IN MEDISOFT.