SPECTRUM
Review Services
25511 Budde Rd, BLDG 1201
The Woodlands, TX 77380
P:800-258-5055

# Prior Authorization Request Form for Health Care Services

**All (*) fields are required. To avoid delays, complete form in its entirety, attach clinicals and fax to the following #:**

**Spectrum Review Services, LLC @ 281-292-6433**

***Section I- Patient Information**

Patient Name:_____ DOB:_____ Male ☐ Female ☐ Single ☐ Married ☐

Address: _____ City:_____

State: _____ Zip: _____ Phone:_____ Last 4 of SS#: XXX-XX-_____

Ins Group #: _____ Member ID#: _____ ☐ Active Subscriber ☐ Spouse ☐ Dependent

Subscriber Name (if different): _____ DOB:_____

***Section II-Ordering Provider** *** Section III-Servicing Facility**

| | |
|---|---|
| Name: | Name: |
| NPI#: | NPI#: |
| Address: | Address: |
| City/ST/Zip: | City/ST/Zip: |
| Phone #: | Phone #: |

***Section IV- Services Requested (Include Procedure Description, CPT code, and supporting ICD/Dx codes)**

***Scheduled Date of Service:** _____ ☐Inpatient ☐Outpatient

| Procedure/Service Description | CPT Codes | ICD/Dx Codes |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***Supporting Documentation MUST BE attached. Are supporting clinicals attached**? ☐ YES

☐Physical Therapy ☐Occupational Therapy ☐Speech Therapy ☐Cardiac Rehab ☐Mental Health/PHP

**MUST have signed MD order for therapy attached**. Order attached? ☐Yes Eval and Treatment Plan attached: ☐Yes

Number of sessions: _____ Frequency: _____ Duration:_____

*Contact Person/Completed by: _____

*Contact Phone #:_____ *Return Fax #:_____

***Please allow up to 72hrs to process authorization requests***
***ALL authorizations will be sent via fax, please confirm a good fax # is provided***

**Insurance/SRS use only**

Authorization valid dates: _____ thru _____

Authorization #: _____ ***Authorization # is not a guarantee of payment***