Gordian Health Management Group

Phone: 817-877-0770
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CARE MANAGEMENT INFORMATION FORM

PRE-AUTHORIZATION ☐ *** REFERRAL** ☐ **EXPEDITED REQUEST** ☐

***HEALTH PLAN/Payor** ___________________________ **Precert Phone #**_______________________

Patient/Coverage Data

***Inquirer:**____________________________________ ***Date:**_________________________________

***Inquirer phone:** ______________________________ ***Fax #:** ________________________________

***PCP and ID #:**____

***Requesting Specialist and ID #:** ____

Member ID #** _______________________________Proposed date of service** ________________________

***Patient name:** ______________________________ DOB: ________ Social Security number: _______________

Facility Name /Name of Service Provider (Home Health, DME):____

Outpatient G **23 hr. Observation G** **Inpatient G** **Ambulatory G** **Home Health G** **DME G**

Clinical Data

***Diagnosis**: ____ *** ICD 9 Code(s)** ______________

Procedure ___________________________________ Outpatient Procedure Code(s)(CPT4): ________________

*Describe specialist services requested and number of visits authorized: ____________________________________

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Please submit clinical history (signs/symptoms, tests, previous treatment, and/or progress notes for **ALL** pre-authorization requests).

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Please describe, if applicable, any special circumstances which (which includes but is not limited to disability, acute condition or life-threatening illness) may require flexibility in the application of screening criteria:

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Care Management Use Only

Pre-authorization number: _____________________

Referral number: ____________________________

Expiration date: _____________________________

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.