



PRIOR AUTHORIZATION REQUEST

Please fax to 330 996-8904

**For urgent requests only, please call 330 996-8710 or 888 996-8710*

DATE _____

MEMBER NAME _____

LAST

FIRST

MI

MEMBER ID # _____ MEMBER DOB _____

ORDERING PHYSICIAN

NAME _____ TAX ID # _____

LAST

FIRST

PHONE # _____ FAX # _____

OTHER CONTACT NAME _____ PHONE # _____

PROCEDURE ORDERED _____ **DATE OF SERVICE** _____ **DIAGNOSIS** _____

CPT CODE(S) _____ **ICD-9 DX CODE** _____

ELECTIVE ADMISSION

GENETIC TESTING

OUTPATIENT SURGERY

Patient Counseling Completed

IMAGING

Basic Elements of Informed Consent for Genetic Testing

OUT OF NETWORK REFERRAL

Basic Elements of Informed Consent for Cancer Susceptibility

NEW TECHNOLOGY

By signing, I certify that the member above has been counseled according to guidelines checked above.

OTHER _____

Physician's Signature _____

SERVICE REQUESTED _____

PLACE OF SERVICE/FACILITY _____ OUTPT INPT

CLINICAL INFORMATION - PERTINENT TO PROVIDER SERVICE (ATTACH COPIES OF PERTINENT CLINICALS)

Include symptoms/findings, labs, tests, imaging, and conservative treatment, if any.

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AUTHORIZATION # _____

SUMMACARE CONTACT _____