SUMMACARE

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

☐ OUTPATIENT SURGERY
☐ IMAGING
☐ OUT OF NETWORK REFERRAL
☐ NEW TECHNOLOGY

☐ GENETIC TESTING
Patient Counseling Completed
☐ Basic Elements of Informed Consent for Genetic Testing
Basic Elements of Informed Consent for Cancer Susceptibility
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.

AUTHORIZATION #_____

SUMMACARE CONTACT_____