MEDICAL MANAGEMENT
P.O. BOX 5750
Springfield, MO 65801-5750
Toll Free # 1-800-205-7665
Local: 417-269-2813
Fax #:417-269-2919

Medical Authorization Form

Please Type or Print Clearly. Form Must Be Filled Out Completely Prior to CHP Review.

Today's Date:	**Form Completed By:**

1. PATIENT INFORMATION

Patient Name **Last:** **First:** **Middle:**	**DOB (mm/dd/yyyy:**	**Gender:** ☐**Male** ☐**Female**	**11-Digit Patient Insurance ID #:**

2. MEDICAL SERVICE REQUESTED

Referring Provider:	**Phone #:** **Ext.#:**	**Fax #:**

(Please Indicate):

☐**1. Outpatient** ☐ **2. Inpatient** ☐ **3. Partial** ☐ **4. Other:**

Hospital/Facility/or Provider of Service:	**Phone #:** **Ext.#:**	**Fax #:**

Rendering Hospital/Facility/or Provider -*Physical Address (*Required to Determine Benefit):

City*:	**State*:**	**Zip Code*:**	**Tax ID# for Billing* (Required):**
Admission Date* (mm/dd/yyyy):	**# of Days/Units Requested:**	**Start Date (mm/dd/yyyy):**	**End Date (mm/dd/yyyy):**

Diagnosis (ICD-10 Code) With Description (Required): (not for Clinical/Medical Records. Attach separately.):

Procedure Code (CPT Codes) With Description (Required):

3. COXHEALTH Medicare Advantage PLANS USE ONLY

Authorization #:	**Start Date (mm/dd/yyyy):**	**End Date (mm/dd/yyyy):**	**Service (s) Authorized:**

Comments: