Insurance Preauthorization Request

Doctor						**Date**	
Patient #		**Computer #**				**Case type**	
Patient Name						**D O B**	
Insured's name						**D O B**	
Relationship		**Since (Date)**				**Injured/ill since**	
Employer						**Phone**	
Address						**Supervisor**	
City		**State**		**Zip**		**Note**	
Insurance Company						**Phone**	
Address						**Insured's ID#**	
City		**State**		**Zip**		**Group #**	
Contact		**Title**		**Phone**		**Claim #**	
Notes							

Pre-Authorization Request			
Initial Care ☐	Update Care ☐	Primary Insurance ☐	Workers Compensation Insurance ☐
Diagnosis			
Treatment Requested			
Treatment start date		**Treatment end date**	
Treatment particulars; (Number & frequency of visits, etc.)			
Additional requirements; (Traction, Ultrasound, Physiotherapy, Exercise, Diet, etc.)			
Comments and Notes			
Doctor's Signature		**Address & Contact details**	