REV 2/14/2021

Prime Dx
P.O. Box 9201 * Austin, TX 78766
(512) 454-5112 * (800) 477-4625 * FAX (512) 904-7544

Pre-Authorization Form

Please Complete & Submit all requested information at least 72 hours prior to date of Service
PROVIDER & FACILITY MUST BE IN NETWORK
For Benefits and Network Status call Boon-Chapman at 800-252-9653

Include the Following: Patient's History & Physical, Patients Clinic Records/Medical records pertinent to the request, Previous Treatment (including meds, therapy & Response to Treatment, Diagnostic Testing performed including the results).

Patient Name: _____ **Date of Birth:** _____

Group: _____ **Male ☐/Female☐** **Patient Phone Number:** _____

Ordering Physician _____

Contact Person _____ **Tax ID** _____

Address _____ **Phone** _____

Address _____ **Fax** _____

If there is an adverse determination would you like a PEER to PEER? **Yes☐ No☐**

Provider Name: _____

Phone: _____ **Best Time to Contact:** _____

Hospital/Facility/Specialist _____

Providing Services: _____

Contact Person _____ **Tax ID:** _____

Address _____ **Phone:** _____

Address _____ **Fax:** _____

Confidential Health Information Enclosed

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that do not require patient/member authorization. You, the recipient, are obligated to maintain the health care information in a safe, secure and confidential manner. Re-disclosure of the health care information transmitted without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Fax Form to PRIME Dx at 512-904-7544 or email to chrfax@boonchapman.com
EMAILS MUST BE SENT SECURE/ENCRYPTED

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Diagnostic Test:		**Inpatient:**		**PT:**		**Specialty Referral:**	
Home Health:		**Outpatient:**		**OT:**		**DME:**	
		# of Visits:		**ST:**		**# of Visits:**	

Date of Service:

ICD Code(s):

CPT/HCPCS Code(s):

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