

SIERRA HEALTHCARE OPTIONS

SHO/CURB/PRIME

PRIOR AUTHORIZATION REQUEST FORM

SHO/ CURB/ PRIME - ATTN: 2720-2

PHONE: 1(702)242-7340 OR 1(800)873-5791

P.O. BOX 15645, LAS VEGAS, NEVADA 89114-5645

FAX: 1(702)243-8498

PATIENT INFORMATION:

PT'S NAME: _____ DOB: _____ SHO: _____ CURB: _____

INSURED: _____ RELATION: _____ INSURED ID: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMPLOYER: _____ EFF DTE: _____

REQUESTING PROVIDER INFORMATION:

PROVIDER: _____ GROUP NAME: _____

ADDRESS: _____ SUITE: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____ CONTACT: _____ TIN#: _____

PLACE OF SERVICE INFORMATION:

PROVIDER OR FACILITY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____ TIN#: _____

SERVICES: _____ DOS: _____ OUTPT: _____ INPT: _____

SURGICAL: _____ DIAGNOSTIC: _____ SURGEON (IF APPLICABLE): _____

ICD-9 (if known) _____

CPT (if known) _____

CLINICAL FINDINGS: _____

◆ **PLEASE INCLUDE ALL CLINICAL INFORMATION, X-RAY REPORTS, DIAGNOSTIC TEST RESULTS SUPPORTIVE OF THE PROCEDURE(S) REQUESTED.**

APPROVED:

CASE # _____ DATE: _____ PER: _____

ADDL. RCRDS REQ: _____ ROUTED TO MD: _____ PER: _____

THIS DETERMINATION CONSTITUTES A DECISION ONLY AS TO THE "MEDICAL NECESSITY" OF THE PROPOSED TREATMENT, AS THAT TERM IS DEFINED BY THE PLAN DOCUMENTS. THIS FORM IS NOT A GUARANTEE OR BENEFIT PAYMENT.

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