

EMPLOYEE NAME _____

PATIENT NAME _____ PATIENT DOB _____

COVERAGE INFORMATION		PLEASE CIRCLE MEMBER'S GROUP	
POLICY NUMBER _____	MidMichigan Health	Northwood University	
GROUP NUMBER _____			

PHYSICIAN NAME: _____

<input type="checkbox"/> INPATIENT ADMISSION	<input type="checkbox"/> OUTPATIENT PROCEDURE OR SURGERY
<input type="checkbox"/> DME (Attach prescription)	
DATE OF ADMISSION/SURGERY/PROCEDURE _____	
Inpatient admissions and certain outpatient procedures may require preauthorization prior to approval	

FACILITY NAME _____

PLACE OF SERVICE: PROVIDER OFFICE HOSPITAL OTHER
If not INPATIENT

REASON FOR SERVICE: ICD-10 DIAGNOSIS CODE(S) _____
PROCEDURE/CPT 4 CODE(S) _____

DIAGNOSIS _____

Person Making Request _____ Telephone _____

Office or Facility _____ FAX Number _____

Precertification Number _____ Duration _____

Comments _____

Representative _____ Date Received _____