cohere HEALTH

PRIOR APPROVAL FOR MEDICAL SERVICES

SEND COMPLETED FORMS TO COHERE FAX LINE: 1-857-557-6787

Please provide written answers or check appropriate box. Type or print legibly. Where additional space is needed, please attach supplemental sheet(s).

1.PHYSICIAN'S NAME OR AGENCY NAME	**2. PROVIDER #**	**3.** ☐ **M.D.** ☐ **D.O.** ☐ **D.P.M.**
ADDRESS	**TELEPHONE**	

4. MEMBERS NAME	**5. MEMBER ID NUMBER**	**6. SEX** ☐ **Male** ☐ **Female**
7. ADDRESS	**8. DATE OF BIRTH**	

9. HOSPITAL

10. DIAGNOSIS

11. DATE MEMBER FIRST SEEN FOR ABOVE DIAGNOSIS	**12. MOST RECENT VISIT**

13. MEMBERS PRESENT MEDICAL STATUS

14. TREATMENT OR SERVICES RENDERED

15. DATE AND RESULTS OF LAB PROCEDURES AND/OR X-RAYS

16. OPERATION, PROCEDURE, TREATMENT, OR SERVICE FOR APPROVAL	Description	Procedure/Code	Estimated Price Per Unit	Units of Service
1				
2				
3				
4				

17. PLAN OF CARE

18. JUSTIFICATION FOR REQUESTING #16.

19. PHYSICIAN'S SIGNATURE	**20. DATE**
DATE	**SIGNATURE**

** Prior approval applies only to this member unless otherwise specified. The approval applies only if the member is eligible at the time the services are rendered.*

***This request is subject to Retrospective Peer Review.*