

Case Assistance Form

Submit this form via fax to: (855) 952-5783

|  |  |  |
| --- | --- | --- |
| **PATIENT INFORMATION** | | |
| Patient Last Name | First Name | Date of Birth |
| Insurance Name | Insurance ID # | Insurance Phone # |
| MRN | Gender  Male Female | Patient Phone # |
| **ORDERING PHYSICIAN/FACILITY INFORMATION** | | |
| Physician Name | Physician NPI | Physician Tax ID |
| Facility Name | Facility NPI | Facility Tax ID |
| Address | City | State |
| Site Contact Name | Email | Phone |
| **PROCEDURE INFORMATION** | | |
| Procedure Date | Site of Care  Outpatient Office | Number of assessments to request authorization.  4  8  12 |
| CPT Code  93702 | Diagnosis Code | Is this a new request or have you received a denial?  New  Pre-auth appeal  Post-service appeal |
| **ADDITIONAL INFORMATION** | | |
| Can we contact your patient? Yes ☐ No ☐  Can we access your EHR for view only access? Yes ☐ No ☐  Will CPT 93702 be billed under physician or facility tax ID?  Preferred method of contact? Email ☐ Phone ☐  Would you like a weekly report of cases submitted through the program? Yes ☐ No ☐ | | |