

Pre-Authorization Request Form

MHMG WorkLink

909 Frostwood, Suite 1:406
Houston, Texas 77024
Phone: 713-338-6519 Option 2
Fax: 713-338-4192

Pre-Authorization Request
Pre-Authorization Reconsideration

I. REQUESTOR INFORMATION

Date of Request	Person Completing Request	Type of Request <input type="checkbox"/> Physician Office <input type="checkbox"/> Facility <input type="checkbox"/> Other _____	Phone Fax
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Name of Ordering Physician: _____ Tax ID # _____

III. INJURED WORKER INFORMATION

Injured worker Name: (Last/First/MI)	Date of Birth / /	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer	Insurance Carrier:	Claim No:	

V. REQUESTED SERVICES BY CPT CODE

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VI. SERVICE DETAILS

Facility/Vendor: _____
Provider: _____
Phone: _____ Fax: _____
Address: _____ Date of Service: _____

VII. CLINICAL INFORMATION (Fax clinical to 713-338-4192 or toll free at 1-888-732-5136)

Primary Diagnosis: _____ ICD-9 Code: _____

Secondary Diagnosis: _____ ICD-9 Code: _____

Medical History:

Supporting Clinical information for requested service: (Describe applicable symptoms, illness duration, pertinent test, treatment)
Is this injured worker disabled (outside the work related injury) and/or have any special needs or circumstances?

yes no (please explain if yes)

****This authorization does not guarantee payment. Final claim determination will be made in writing following receipt and review of the claim and verification of compensability.**

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