MEMORIAL HERMANN Employer Solutions

# 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<br>□ Physician Office □ Facility<br>□ Other _____ | Phone<br>Fax |
|---|---|---|---|

Name of Ordering Physician: Tax ID #

## III. INJURED WORKER INFORMATION

| Injured worker Name: (Last/First/MI) | Date of Birth / / | Age | Sex □ Male □ Female |
|---|---|---|---|

| Employer | Insurance Carrier: | Claim No: |
|---|---|---|

## V. REQUESTED SERVICES BY CPT CODE

## 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.*