**Patient Legal Name**: \_\_\_\_\_\_ **Date of Birth**:

**Patient Phone Number:** ­­

**Procedure Name & CPT Code(s):**

**Diagnosis & ICD-10 Code(s):**

**Special Equipment Needs:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Documents Attached (*check all that apply*):

Text

Description automatically generatedText

Description automatically generated with medium confidence

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Verification:

**Primary:** **Secondary:**

**Phone#:** **Phone#:**

**ID#:**  **ID#:**

**Date Verified**: **Date Verified**: \_\_\_\_\_\_\_\_\_

**AUTH#:** **AUTH#:**

**Inpatient # Days Approved**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Inpatient # Days Approved:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ins. Representative Name**: \_\_\_\_\_\_\_\_\_\_\_\_ **Ins. Representative Name**: \_\_\_\_\_\_

**Call Reference #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Call Reference #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX ALL DOCUMENTS (including this completed page) TO: 307-204-8804**

**Updated 08/2022**