Include the Following: Patient's History & Physical, Patients Clinic Records/Medical records pertinent to the request, Previous Treatment (including meds, therapy & Response to Treatment, Diagnostic Testing preformed including the results.

**Patient Name:  Date of Birth: **

**Group:  Male** [ ] **/Female**[ ]  **Patient Phone Number: **

**Ordering Physician **

**Contact Person  Tax ID **

**Address  Phone **

**Address  Fax **

**If there is an adverse determination would you like a PEER to PEER? Yes**[ ]  **No**[ ]

**Provider Name: **

**Phone:  Best Time to Contact: **

**Hospital/Facility/Specialist **

**Providing Services: **

**Contact Person  Tax ID: **

**Address  Phone: **

**Address  Fax: **

**Diagnostic Test:  Inpatient:  PT:  Specialty Referral: **

**Home Health: Outpatient:  OT:  DME: **

 **# of Visits:  ST:  # of Visits: **

**Date of Service: **

**ICD Code(s): **

**CPT/HCPCS Code(s): **

**Please provide the following information along with this form for consideration.**

* **Patient’s History & Physical**
* **Patient’s clinic records/medical records pertinent to the request**
* **Previous treatment, including medications, therapy & response to treatment**
* **Diagnostic testing performed including the result**
* **ONLY 1 Pre-D will be considered per CPT/HCPCS code**