**Galveston County Indigent Health Care - Pre-Authorization Request Form**

\*\*Please Complete & Submit all requested information at least 72 hours prior to date of Service\*\*

PROVIDER & FACILITY MUST BE IN NETWORK

For Benefits and Network Status call Boon-Chapman at 800-252-9653

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 performed 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: **

**Is Ordering Physician contracted with Galveston CCS? Yes No**

**Hospital/Facility/Specialist **

**Contact Person  Tax ID: **

**Address  Phone: **

**Address  Fax: **

**Is Hospital/Facility/Specialist contracted with Galveston CCS? Yes No**

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**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): **