Hackensack Meridian *Health*

☐ STAT CASE:
Check this box if STAT is needed.

Ordering Physician

Tax ID:_____

NPI:_____

Name:_____

Phone:_____

Fax:_____

Patient Access Services - Insurance Authorization/Verification

Please fax to: 201-295-4046
Phone: 201-295-4040
Email address: PMC-Concierge@hackensackmeridian.org

FAX INFORMATION:
Date:_____ Pages:_____

Patient Name: _____

DOB: _____

Patient phone#: _____

Primary Insurance:_____ ID#_____

Secondary Insurance:_____ ID#_____

Primary Diagnosis:_____ Secondary Diagnosis:_____

In order for us to properly process an authorization request, please include the following information along with this form:

☐ Prescription
☐ Front and back of Insurance Card
☐ List of current medication
☐ Patient Face/Demographic Sheet
☐ Pathology Report (if needed)
☐ R/O or Differential Diagnosis (this will be useful to support why a test is being ordered and often a question that is asked by a clinical reviewer)
☐ Typed or written office notes (which include the following: signs and symptoms, duration of condition, duration of treatments, lab results, and previous radiology reports)

Please note, if additional information is needed we will contact you for the necessary information. Also, be aware it may be necessary for us to contact you for help in interpreting any clinical notes.

***Contact person at MD office:**_____ ext: _____

Imaging/Cardiovascular Center to be utilized

☐ Hackensack Meridian Health Facility (please specify): _____
☐ Other: _____
Address: _____
Fax: _____

OFFICE USE ONLY

Authorization#:
(1):_____ Expires:_____

(2):_____ Expires:_____

(3):_____ Expires:_____

(4):_____ Expires:_____

<Date> Received:_____ Initiated:_____ Approved:_____
Name of rep.:_____Case/ref#:_____
Completed by:_____ Member Scheduling?: Y / N