MEMORIAL HERMANN Health Solutions

Pre-Authorization Request Form

Memorial Herman Health Solutions
WorkLink
7737 Southwest Freeway, Suite C-99
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 □ Physician Office □ Facility □ Other ___________________________	Phone 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.***

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