



## BUCKEYE PRE-SERVICE FAX REQUEST FORM

(Requests **MUST** include most recent clinical information in order to be considered. Incomplete requests will be denied for lack of information)

DATE OF REQUEST:	/ /	DATE OF APPT:	/ /
MEMBER NAME:		DOB:	
BUCKEYE MEMBER ID NUMBER:	BUCKEYE GROUP NUMBER:	ORDERING PHYSICIAN:	First, Last name
OFFICE CONTACT NAME:	PHONE: ( )	FAX:	( )
PRACTICE / GROUP NAME:		CPT CODE:	

### PLEASE COMPLETE STEPS 1-4

<b>1. PROCEDURE / SERVICE / EQUIPMENT:</b>	
<b>2. CPT CODE(S):</b>	

<b>3. IF OUTPATIENT SERVICE, NUMBER OF VISITS REQUESTED: _____</b>	
<b>4. IF DME, LIST PURCHASE PRICE:</b>	
a.	Date of Service:
b.	To be scheduled:
c.	Facility / Place of Service:
d.	Inpatient <b>or</b> Outpatient:
e.	<b>DIAGNOSIS:</b>

<b>4. CLINICAL INFORMATION PERTINENT TO PROCEDURE / SERVICE – (ATTACH ADDITIONAL OFFICE NOTES)</b>	
▶	<b>SYMPTOMS:</b>
▶	<b>ASSESSMENT / LAB VALUES / PREVIOUS TEST RESULTS:</b>
▶	<b>CONSERVATIVE TREATMENT:</b>

**PLEASE REFER TO THE QUICK REFERENCE GUIDE ON OUR WEBSITE [WWW.BCHPOHIO.COM](http://WWW.BCHPOHIO.COM) FOR THE APPROPRIATE NUMBER FOR FAXING THIS FORM FOR PRIOR AUTHORIZATION**

<b>Authorization Number:</b>		<b>Pre-certification Not Required:</b>	
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#### Protected Health Information

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