Revenant Healthcare
REINVENTING ANALYTICS

Please fill out the form up to the dotted line. Please note that without these documents, the preauthorization will not be completed.

-Patient's Clinical's (Up to 90 day's)

-Demographic Face Sheet

-A copy of the patient's insurance card (Front and Back)

Please select an option below:

- ◯ I'm submitting for a new pre-authorization
- ◯ I'm submitting for documentation because my staff has initiated a pre-authorization already.

Medical Provider Name_____ Clinic Name_____

Tax ID #_____ Clinic Phone Number_____

Provider's NPI# _____ Clinic Fax Number _____

Patient's Insurance ID Number_____ Clinic Fax Number _____

Patient's DOB_____ Estimate Date of Procedure_____

Patient ID: ☐ First Initial of First Name ☐☐☐☐☐ First 5 Letters of Last Name ☐☐ 2 Digit Year of Birth of Birth

HCPCS (Q-Codes) & Units

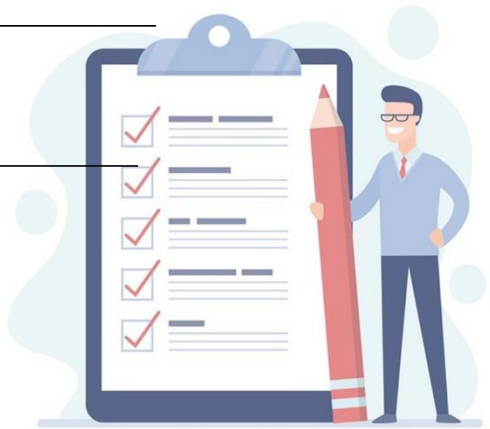
- ☐ Q4206 - Fluid Flow _____Units
- ☐ Q4226 - MyOwn Skin _____Units
- ☐ Q4205 - Membrane Wrap _____Units

CPT Procedure Codes

_____

ICD-10 Diagnosis Codes

_____



---------- FOR OFFICE USE ONLY ----------

Authorization # _____ Effective _____

Issued By _____ Date _____

Comments:

_____

Documented By

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