

PREAUTHORIZATION REQUEST



Fax form to: (855) 287-4028

Phone: (800) 844-4235

Include all supporting clinicals/imaging/documentation and signed orders (if applicable) with your request.

Patient information

Texas Mutual claim number		Date of injury		
Patient first name	Patient last name		Date of birth	
Address		City	State	ZIP
Phone number				

General information

Review type Non-Urgent Urgent | Clinical reason for urgency

Request type Initial request Appeal

Provider information

Requesting provider or facility		Service provider or facility	
Name		Name	
Tax ID	NPI	Tax ID	NPI
Phone	Fax	Phone	Fax
Contact name		Contact name	
Specialty		Specialty	

Services requested (with CPT, CDT or HCPS code) and supporting diagnoses (with ICD code)

Planned service or procedure	Code	Start date	End date	Diagnosis description (ICD version ____)	Code

Inpatient Outpatient Provider office Observation Home Day surgery Other

Physical therapy Occupational therapy Speech therapy Home health (MD signed order attached? Yes No)

Number of sessions Duration Frequency Other

Miscellaneous information

Contact information for peer review (if needed)

Contact person	
Phone number	Fax number

Revised Nov. 2021