North Carolina Industrial Commission

IC File #_____

Date of Injury_____

REQUEST FOR PREAUTHORIZATION OF MEDICAL TREATMENT

Employee's Name		Requesting Provider	( ) Telephone Number
Address		Provider Billing Address	City State Zip
City	State Zip	Tax ID	
( ) Home Telephone	( ) Work Telephone	Form Prepared By	
XXX-XX- Last 4 digits of SSN	☐ M ☐ F Sex / / Date of Birth	( ) Telephone Number	Email Address

1. The health care provider above requests preauthorization for the following surgery or inpatient admission and all pertinent clinical documentation regarding this request is attached.

Diagnosis: _____ Facility/Place of Service: _____

Setting: _____ Address: _____

Outpatient or Inpatient Phone & Fax: _____/_____

Diagnosis Code ICD-9:: _____ Tax ID: _____

Principal CPT Code: _____ Billing Contact: _____

2. Requested Service (include description, including body part(s)):

_____

_____

_____

_____

3. Frequency and Date(s) of Service (include date or length of service and admission date for inpatient treatment):

_____

_____

4. To be completed by Insurer: Procedure/Admission is ☐ Authorized.(or) ☐ Denied upon initial review. (Attach any explanation for decision or state additional information needed.) Insurer determinations shall be sent to all interested medical providers.

Date Completed: _____ Company Name: _____

Signed By: _____ Official Title: _____

Print Name: _____ Preauthorization Number: _____

This form shall be transmitted by the health care provider to the insurer at the e-mail address or fax number designated in the insurer's preauthorization review policy:

CLAIMS ADJUSTER OR DESIGNATED PREAUTHORIZATION AGENT: _____

FAX NUMBER: _____

EMAIL: _____

Form 25PR

North Carolina Industrial Commission

IC File #_____

Date of Injury_____

Employee Name_____

REQUEST FOR PREAUTHORIZATION OF MEDICAL TREATMENT (CONTINUED)

PROVIDER TO COMPLETE THIS PAGE TO APPEAL INITIAL DENIAL OF REQUEST.

Review Professional	Requesting Provider ( ) Telephone Number
Address	Provider Billing Address City State Zip
City State Zip	Tax ID
Email Address ( ) Telephone	Form Prepared By
	( ) Telephone Number Email Address

1. Professional Qualifications and Areas of Specialty and State(s) of Licensure of Review Professional:

2. Review Findings and Determination (G.S. 97-25.3(a)(4)):

3. Procedure is ☐ Authorized (or) ☐ Denied. (Complete 2 above and attach any further explanation for decision or state additional information needed.) Insurer determinations shall be sent to all interested medical providers.

Date Completed: _____ Peer To Peer Conducted? ☐ **YES** ☐ **NO**

Signed By: _____ Date: _____

Print Name: _____ Precertification Number _____

This form shall be transmitted by the health care provider to the insurer at the e-mail address or fax number designated in the insurer's preauthorization review policy:

CLAIMS ADJUSTER OR DESIGNATED PREAUTHORIZATION AGENT: _____

FAX NUMBER: _____

EMAIL: _____

Form 25PR