Completed Form can be faxed to: (847) 741-1290

OR

Emailed to: hinesreferral@hinesassoc.com

RN Consult/Prior-Auth Physician Review Request Form

Date Submitted: ______________________ Telephone: ______________________

PICK ONE:

☐ RN Consult Request - Non-Urgent ☐ RN Consult Request – URGENT

(No prior TPA RN review. Starts with a Hines UR RN and move to Prior-Auth Physician Review if needed which will be automatically transition from RN consult to Prior-Auth Physician Review.)

☐ Prior-Auth Physician Review – Non-Urgent* ☐ Prior-Auth Physician Review – URGENT*

(TPA RN already reviewed, case needs Prior-Auth Physician Review)

REQUESTOR:

Name/Title: ______________________

Company Name: ______________________

CLAIMANT:

Name: ______________________ DOB: ______________________

Address: ______________________ City, State, Zip: ______________________

Telephone #: ______________________

INSURED:

Name: ______________________ Relationship: ______________________

Policy #: ______________________

DETAILS:

DOS: ______________________ Diagnosis: ______________________

Procedure/Service: ______________________

FACILITY/HOSPITAL:

Name: ______________________

Address: ______________________ City, State, Zip: ______________________

Telephone #: ______________________

PHYSICIAN:

Name: ______________________

Address: ______________________ City, State, Zip: ______________________

Telephone #: ______________________

*Medical necessity of the services indicated on this form will be reviewed. Please indicate any additional questions you wish addressed:

_____