Medical Approval Form

NOTICE TO PROVIDER: This policy is a secondary policy. If claimant has coverage through any other carrier that policy will be primary. If primary coverage exists approval must be requested from the primary insurance carrier.

If there is no other coverage then this policy will act as primary and the following services require pre-approval: surgeries, MRI's, CT scans, durable medical equipment and physical therapy. All fields are required and must be complete. Incomplete requests and requests that are not properly coded with CPT or HCPCS cannot be processed and will be returned. Please fax completed form to: 806-337-1859.

Claimant Name_____ Date of Birth____/_____/_____

Group Name __Player Development, L.L.C._____ Date of Injury____/_____/_____

Requesting Phys._____	Requesting Provider_____
Address_____	Address_____
_____	_____
Phone_____	Phone_____
Fax_____	Fax_____
Contact_____	Contact_____

DX	HCPCS/CPT	Description of Item/Service	Body Part	Select One	Date of Service Begin	End
				□ Right □ Left		
				□ Right □ Left		
				□ Right □ Left		

Date Request Submitted_____/_____/____ □ New Request □ Revised-Request

THIS SECTION TO BE COMPLETED BY FAIRLY GROUP:

Request:
□ Approved
□ Denied
□ Pending

Comments_____
_____
_____

Further as permitted by applicable law, this pre-approval is subject to concurrent review as to medical necessity, appropriateness of efficacy, and coverage for services being provided. Billing for the services preapproved on this form is subject to nationally standardized rules for coding and payment. In absence of authorization, silence is acceptance of an offer of payment pursuant to current Medicare reimbursement and reduction of all complex and very complex CPT codes to simple to moderate CPT codes.