



Prior Authorization Form
Cardiac & Pulmonary Rehab

Please indicate the type of rehabilitation you are requesting:

Cardiac

Pulmonary

Patient's Name: _____ DOB: _____ ID# _____

Ordering Physician: _____ Clinic: _____

Rehabilitation Provider: _____ Tax ID: _____ NPI: _____
Name/Specialty/Clinic

Phone: _____ Fax: _____

Diagnosis: _____ ICD-10: _____

Is this a Worker's Comp or accident case? Yes No

Dates of service requested: _____

Number of visits requested: _____

Provider Contact Name	Phone #	Fax #	Date

Prior authorization is required prior to any services being rendered. Services must be prescribed by a Physician to be considered a covered benefit.

Privacy and Confidentiality:

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