



Goshen Hospital

Pre-Authorization Form

Please Fax completed form to Patient Access 574-364-2410

Date: _____

Patient: _____ **DOB:** _____

Ordering Physician: _____

Physician Rep: _____

Procedure: _____

Date of Procedure: _____ **CPT Code:** _____

W/ Contrast _____ **W/O Contrast** _____ **W/WO Contrast** _____

Insurance Phone # _____ **Date Called:** _____ **Time:** _____

Insurance: _____ **Insurance Rep:** _____

Authorization # _____

Call Reference # _____

Insurance Company Authorized for (PLEASE CHECK BOX)

**Inpatient
(IN)**

Outpatient

**Surgical
(DS/SDC)**

of days approved: _____

Auth Date: _____ **Expiration Date:** _____

***BOLD fields are REQUIRED when applicable**

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