

Health Plus of Louisiana
Pre-Authorization Request
Health Plus Requires 2 Working Days for Elective Procedures
and Requests 4-5 Working Days Advance Notice to Allow Time for Collecting Information

Date Requested: _____ Number of Pages Sent: _____
Requested By: _____
Physician's Phone Number: _____
Physician's Fax Number: _____
Referral Number from Referring Physician: _____

Admitting Physician:	Physicians Tax ID #:
Patient Name:	Employee / Insured Name:
Patient DOB:	Employee / Insured HPL ID #:
Planned Date of Service:	Facility:

- I. Check Level of Care Requested ()-Inpt. Admission ()-Observation ()-Outpatient Surgery
- II. Diagnosis (include all ICD-9 codes): _____
- III. Procedure (include all CPT codes): _____

- IV. Please provide all pertinent CLINICAL INFORMATION regarding requested procedure(s) [Abnormal Lab Values, Radiologic Findings, History, Abnormal Physical Findings-Fax Copies to 318-676-3376]

HPL Approval #: _____ Issued By: _____
(Internal Use Only)

PREAUTHORIZATION DOES NOT GUARANTEE FINANCIAL REIMBURSEMENT. PAYMENT FOR SERVICES IS CONTINGENT UPON THE COVERED PERSON'S ELIGIBILITY AND BENEFITS AT THE TIME SERVICES ARE RENDERED.

If you have any questions please contact HPL at (318) 212-4499 [outside of S'port/Bossier Metro area at (800) 331-5055, ext. 4499].

**FAX THIS FORM WHEN COMPLETED TO
HPL CARE MANAGEMENT PREAUTHORIZATIONS AT (318) 676 - 3376**