PROCEDURE AUTHORIZATION

PHYSICIANS

Injured Party Information

Please fill out the form completely.

Patient Name*:

Date of Accident*:

Phone*:

DOB*:

Referring Physicians Name (RP)*:

Phone*:

Fax*:

Scheduled Procedure/Treatment Plan

Date of Procedure*:

CPT Coding for Procedure*:

Description of Procedure/Treatment*:

Treating Facility*:

Estimated Procedure/Treatment Cost*:

Initial Date of Service*:

Attorney Information

Firm Name*:

Contact at Firm*:

Phone*:

Procedure Approved (Signature):

Date:

Print Name:

Please include the patient-signed 2-page Red Rock Intake Form.

Submit form via email to PreAuth@RedRockDiagnostics.com

Or fax: (702) 202-2052

Questions? Call us at (877) 362-6077

RED ROCK DIAGNOSTICS