Date:

To:

From:
Phone:
Fax:

Pages:

Necessary information for an authorization, please fill in the sections below:

- **Ordering physician tax identification number:**
- **Ordering physician first and last name:**
- **Referred to provider (restrictions may apply, please see MyGroupHealth for Providers website):**
- **Referred to provider location (if applicable):**
- **Diagnosis with ICD-9 code(s) (2 maximum):**
- **CPT or Drug code(s):**
- **Number of visits:**
- **Start date of authorization:**
- **Patient ID number:**
- **Patient first and last name:**
- **Patient DOB:**

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