

TRUST FUND OFFICE
PO Box 11337, Reno NV 89510
(775) 826-7200 Fax: (775) 826-7289

REVIEW NOTIFICATION COMPLETION TIMES: STATS-72 Hours; ROUTINE-up to 15 calendar days. Requests needing additional information or Medical Review-up to 45 working days. STAT requests are reserved for urgent/emergent situations and NOT because the service or procedure was scheduled before a request was submitted.

DATE REQUESTED: _____ REQUESTOR NAME & FAX # _____

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

GENDER: _____ RELATIONSHIP TO INSURED: SELF / SPOUSE / DEPENDENT

FUND NAME: --ELECTRICAL WORKER--or--LABORER--or--OPERATING ENGINEER--or--P & P 350

UNION LOCAL NO.: _____ EMPLOYER: _____

INSURED'S NAME: _____ ID NUMBER.: _____ - _____ - _____

IS THE TRUST FUND PRIMARY: YES / NO OTHER INSURANCE: _____

OTHER INSURED'S NAME: _____ OTHER INSURED'S POLICY #: _____

ADMIT / PROCEDURE DATE: ____/____/____ OUTPATIENT/INPATIENT/IMAGING TYPE: SCHED / ER / URG / RETRO

FACILITY / POS: _____ City/State: _____ Phone: _____ PPO : Yes/NO

PHYSICIAN NAME: _____ PHONE #: (____) _____ - _____ PPO : Yes/NO

ASST. SURGEON: _____ FAX #: (____) _____ - _____

DIAGNOSIS:

ICD-10/DESCRIPTION: _____ ICD-10/DESCRIPTION: _____

ICD-10/DESCRIPTION: _____ ICD-10/DESCRIPTION: _____

PROCEDURE:

CPT/DESCRIPTION: _____ CPT/DESCRIPTION: _____

CPT/DESCRIPTION: _____ CPT/DESCRIPTION: _____

REFERENCE NUMBER: _____ GIVEN BY: _____ ON: _____

****THIS AUTHORIZATION DOES NOT INCLUDE INTRAOPERATIVE MONITORING OR OTHER ANXILLARY SERVICES****

THE REFERENCE NUMBER ASSIGNED TO THIS REQUEST FOR SERVICES IS BASED SOLELY ON THE REPRESENTATION AND INFORMATION PROVIDED BY THE PHYSICIAN/FACILITY AND DOES NOT GUARANTEE PAYMENT FOR ANY INCURRED CHARGES. VERIFICATION OF BENEFITS AND ELIGIBILITY IS THE RESPONSIBILITY OF THE PHYSICIAN AND FACILITY.

THIS AREA IS FOR INTERNAL USE ONLY

NOTES: _____

ADMIT NOTE / OP NOTE / DISCHARGE NOTE DC DATE: ____/____/____ FAXED _____

TOTAL DAYS AUTHORIZED: _____ : WHY? _____

*Non-Preferred Provider (physician, facility, etc.) letter sent to insured & requestor: Sent on: _____ Initials: _____