To: Eligibility Dept

Fax number: **737-402-7752**
Eligibility@altruahealthshare.org

1-888-244-3839
www.altrualhealthshare.org

Please include all information requested as well as any medical records/clinical documentation that is associated with requested service and diagnosis to be considered for review.

Please allow 48-72 hours to process Eligibility/Pre-Authorization Requests once all required information and/or records are received.

**** Only dictated/typed documentation will be accepted, no handwritten notes will be accepted.**

Number of Pages (including Cover Sheet): _____

Review Type:
☐ Urgent, ☐ Non-urgent, clinical reason for Urgency:

_____

☐ Initial request, ☐ Extension/renewal/amendment,
Prev. case.#: _____

Treating physician: _____

Phone: _____ Fax: _____

Facility name: _____

Phone: _____ Fax:

Contact Name: _____

Title: _____ Department: _____

Contact Phone: _____

Contact Fax: _____

Date of Request: _____

Anticipated DOS: _____

Member Name: _____

Member ID: _____

Member DOB: _____

Requested CPT(s): _____

_____

Associated ICD-10(s): _____

_____

_____

Comments: