



**AMERICAN HEALTH MEDICARE**  
**Pre-authorization Referral Form**  
**Fax to (787) 620-0925**  
**Pharmacy 1-866-300-3591**

Expedite  
 Standard

<b>Member Name:</b>	<b>Member ID#:</b>
<b>Referred By:</b> (Provider Name):	<b>Referred To:</b> (Provider Name):
<b>Referred By:</b> (Provider Phone #):	<b>Referred To:</b> (Provider Phone #):
<b>Referred By:</b> (Provider Fax #):	<b>Referred To:</b> (Provider Fax #):
<b>Referred By:</b> (Provider ID #):	<b>Referred To:</b> (Provider ID #):
Date of Request: _____/_____/_____	
Diagnosis:	ICD-9 Code(s):
Requested Service: (See back for services that require pre-authorization):	CPT/HCPCS Code(s):

**Supportive Clinical Information**

Related Sign and Symptoms (Specify Duration of Sx.):

\_\_\_\_\_

\_\_\_\_\_

Treatment (Specify Doses, Frequency):

Current Treatment:

\_\_\_\_\_

Past Treatment:

\_\_\_\_\_

\_\_\_\_\_

Related Studies and Findings:

\_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_  
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**Medical Management Response**

( ) Approved as Requested: Authorization Number \_\_\_\_\_ # of Visits Authorized \_\_\_\_\_

( ) Not Approved as Requested:  Additional Information Needed (See attached letter)  No Referral Needed  Criteria Not Met

Comments:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**ALL AUTHORIZATIONS ARE VALID FOR 90 DAYS FROM THE DATE OF AUTHORIZATION**