Progressive Care Network Authorization Request Form
Phone: 317-596-2805 Fax: 317-596-2809

Return to: ____________________Company: ___________________Date: __________

Phone: _____________________ Fax: ___________________

Patient Name: ____________________________________ D.O.B. _________________

Social Security Number: ______________________

Primary Insurance: ______________________ Member Number__________________

Secondary Insurance: _____________________ Member Number: _________________

Ordering MD: ______________________ Phone Number: _______________________

ICD9: ________ / ________ / ________ / ________ / ________ / ________

HCPC Code	Item Description	Unit	Start Date	End Date	Comments

IN ORDER TO OBTAIN AUTHORIZAITON THE FOLLOWING DOCUMENTS ARE NECESSARY. DEMOGRAPHICS, ORDERS AND SLEEP STUDIES. FEEL FREE TO SEND ANY ADDITIONAL DOCUMENTATION AS WELL.

ANY FORMS THAT ARE NOT COMPLETE ARE SUBJECT TO BE RETURNED.