PREAUTHORIZATION REQUEST

Texas Mutual® WORKERS' COMPENSATION INSURANCE

Fax form to: (800) 852-1805 Phone: (888) 532-5246

Include all supporting clinicals/imaging/documentation and signed orders (if applicable) with your request.

Patient information

Texas Mutual claim number		Date of injury	
Patient first name	Patient last name		Date of birth
Address	City	State	ZIP
Phone			

General information

Review type ☐ Non-urgent ☐ Urgent | Clinical reason for urgency

Request type ☐ Initial request ☐ Appeal

Provider information

Requesting provider or facility		Service provider or facility	
Name		Name	
Tax ID	NPI	Tax ID	NPI
Phone	Fax	Phone	Fax
Contact name		Contact name	
Specialty		Specialty	

Services requested (with CPT, CDT or HCPS code) and supporting diagnoses (with ICD code)

Planned service or procedure	Code	Start date	End date	Diagnosis description (ICD version ____)	Code

☐ Inpatient ☐ Outpatient ☐ Provider office ☐ Observation ☐ Home ☐ Day surgery ☐ Other

☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Home health (MD signed order attached? ☐ Yes ☐ No)
Number of sessions Duration Frequency Other

Miscellaneous information

Contact information for peer review (if needed)

Contact person	
Phone	Fax

Revised Oct. 2020