America's TPA®
Medication Management

Date______________________

OUTPUTPATIENT UTILIZATION REVIEW FORM

For assistance, please contact us at (800) 444-5769 Fax (952)896-1261

Patient____ DOB____________GENDER_____________

ID#_____________________________________ Policy Holder____________________________

Patient Address____
(Street) (City) (State) (Zip)

Patient Phone #____

Physician_________________________________ Phone #___________________________________

Facility ____TIN____________________

Address____
(Street) (City) (State) (Zip)

Diagnosis Codes ICD9:___________ICD9:___________ICD9:___________ICD9:___________

Procedure Codes: CPT/HCPC: ____________CPT/HCPC: ____________CPT/ HCPC:____________

Symptoms____

____

History____

____

Treatment to Date____

____

Treatment Plan ____

____

Current Medications ____

____

Other ____

____

Provider's Signature ______________________________________ Date_________________________

For prompt review, please have all questions answered. Please fax, attn: Medical Management, to (952)896-1261, along with supporting clinical.

It is our privilege to serve you.