TRIAD HEALTHCARE
MUSCULOSKELETAL HEALTH SERVICES

CONFIDENTIAL INFORMATION

Triad Authorization Fax Form

Please fax this form and medical records to Triad 1-800-520-8045

MEDICAL RECORDS MUST BE SUBMITTED WITH THIS FORM

Member Name _____ Date of Birth _____

Member ID Number _____ ☐ Male ☐ Female

Who will provide requested services? _____

Blue Cross Blue Shield Provider ID Number _____

Provider of Requested Services NPI _____ Tax ID _____

Provider of Requested Services Address _____

City _____ State _____ Zip _____

Provider of Requested Services Phone ( ) _____ Fax ( ) _____

Services Requested (CPT© Code) _____

Diagnoses (ICD-9/10 Code) _____

Anticipated Date of Service _____

Name of Person Submitting Prior Authorization _____ Telephone Number ( ) _____

Site of Service ☐ Inpatient ☐ Outpatient ☐ Observation

(If Inpatient/Outpatient or Observation are selected, facility information below is required.)

☐ Office ☐ Home

Facility Name _____ Blue Cross Blue Shield Facility ID Number _____

Facility Address (Street) _____

Facility Address (City) _____ (State) _____ (Zip Code) _____

Please provide medical documentation from onset/date of injury, including but not limited to: exam narrative, office notes, results of diagnostic tests and/or any equivalent notes which demonstrate your patient's condition and/or progress to date. Submission of this form, without medical records, will limit our ability to administer prior authorization.