

## Addition Of Services During An Existing Care Plan

Physician Name \_\_\_\_\_ Tax ID Number \_\_\_\_\_

Office Number (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_

---

1. Patient Name \_\_\_\_\_ Patient ID # \_\_\_\_\_

2. Prospective auth reference number (P -----/-----) from your determination letter \_\_\_\_\_

3. What are the additional service requests to the noted authorization above?

---

---

---

---

---

---

---

---

---

---

**The above request will follow Triad’s prospective review process and be medically managed. Please be aware that your request will affect the above referenced certification. An amended care plan cannot be submitted to request a certification extension. If your patient’s condition has changed since the submission of the prior care plan, you must submit an extension of care form.**