Patient Label:

SHARON REGIONAL HEALTH SYSTEM
Advanced Care Close to Home
Behavioral Health Services

Insurance Information Authorization

PRIMARY INSURANCE

Policy #_____ Group #_____

Benefit PH #_____

Precert PH #_____

Contact Person_____

Auth./Ref. #_____

Auth. For Tx by_____

Days Approved_____

Ambulance Transfer:

Auth.:_____

Actions Taken:_____
_____

SECONDARY INSURANCE

Policy #_____ Group #_____

Benefit PH #_____

Precert PH #_____

Contact Person_____

Auth./Ref. #_____

Auth. For Tx by_____

Days Approved_____

SUMMARY OF CONTACTS:_____

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_____ _____ _____
Staff Signature ***Date*** ***Time***