SOUND HEALTH & WELLNESS TRUST
PRESCRIPTION PRE-AUTHORIZATION REQUEST FORM

TO: SOUND HEALTH & WELLNESS TRUST CUSTOMER SERVICE FAX # 206-282-0705
CLINIC / PROVIDER NAME:_____ PH#: _____
FAX#: _____ ADDRESS: _____

Please type or print legibly

Date _____

Ordering Physician: _____ Physician Phone: _____

Member Name: _____ Member SS/ID #: _____

Patient Name: _____ Patient Date of Birth: _____

Name of Drug: _____Strength: _____

Dosage: _____ Estimated Date of Delivery (for Pre-natal vitamins): _____

Diagnosis/ICD-9 Code: _____

Duration of Treatment: _____

Treatment Plan : _____

_____

_____

_____

Additional Information Needed:

Treatment Notes from Physician

Other:_____

_____

For Sound Health & Wellness Trust Use Only:

Pre-Auth Received Date: _____ Pre-Auth Approval/Denial Date: _____

Approved _____ Denied _____ Additional Information Needed (see above) _____

Pre-Auth Term Date: _____