



Fax number: **737-402-7752**

Eligibility@altruahealthshare.org

1-888-244-3839

www.altruahealthshare.org

Please include all information requested as well as any medical records/clinical documentation that is associated with requested service and diagnosis to be considered for review.

Please allow 48-72 hours to process Eligibility/Pre-Authorization Requests once all required information and/or records are received.

**** Only dictated/typed documentation will be accepted, no handwritten notes will be accepted.**

To: Eligibility Dept

Number of Pages (including Cover Sheet): _____

Review Type:

☐ Urgent, ☐ Non-urgent, clinical reason for Urgency: _____

☐ Initial request, ☐ Extension/renewal/amendment,
Prev. case.#: _____

Treating physician: _____

Phone: _____ Fax: _____

Facility name: _____

Phone: _____ Fax: _____

Contact Name: _____

Title: _____ Department: _____

Contact Phone: _____

Contact Fax: _____

Date of Request: _____

Anticipated DOS: _____

Member Name: _____

Member ID: _____

Member DOB: _____

Requested CPT(s): _____

Associated ICD-10(s): _____

Comments: