CarpalAID®

TREATMENT AUTHORIZATION REQUEST

MEMBER INFORMATION

PATIENT'S NAME : _____

DATE OF BIRTH : _____

INSURANCE AND MEMBER ID# : _____

ICD-10 CODE AND DESCRIPTION :

- ☐ G56.0 Carpal Tunnel Syndrome
- ☐ G56.00 Carpal Tunnel, Unspecified Upper Limb
- ☐ G56.01 Carpal Tunnel, Right Upper Limb
- ☐ G56.02 Carpal Tunnel, Left Upper Limb

CPT CODE AND DISCRIPTON : _____

ADDITONAL INFORMATION : _____

_____

_____

_____

DATE OF OFFICE VISIT AND SERVICE : _____

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION

REQUESTING PROVIDER : _____

ADDRESS : _____

CONTACT AT REQUESTING PROVIDER : _____

PHONE NUMBER : _____ **FAX NUMBER :** _____

PROVIDER'S SIGNATURE AND DATE : _____

License # : _____