FCL

Pre-authorization Form

Completion of this form does not guarantee payment of claims. Incomplete forms will not be processed

SECTION 1

TODAY'S DATE: ____ / ____ / _____ PROCEDURE DATE: ____ / ____ / ____ # VISITS/DAYS REQUESTED __________

PERSON COMPLETING FORM: ________________________ PHONE # ___________________ FAX # _____________________

SECTION 2 – MEMBER/PATIENT INFORMATION

NAME: ____ DOB: _______________________

ID# _____________________________________

SECTION 3 – REQUESTING PROVIDER

NAME: ____ PROVIDER#: ________________________

SECTION 4 – SERVICING PROVIDER

NAME: ____ PROVIDER#: ________________________

DIAGNOSIS: ____ ICD - CODES: __________ ___________ __________

SECTION 5 – SERVICES REQUESTED

Write in requested codes

PROCEDURE ____ CPT CODES: ___________ ___________ __________

SECTION 6 – CLINICAL INFORMATION

SECTION 7 - INSTRUCTIONS

1. Fax to StarDent at 1-281-313-7155. Faxed ______________
2. For questions or additional information, please call 1-800-660-6064.

ADDRESS

FIRST CONTINENTAL LIFE & ACCIDENT INS CO.

12946 DAIRY ASHFORD, SUITE #360

SUGAR LAND, TX 77478

For FCL Use Only Pre-authorization # ______________________

Note: This list may be amended by FCL from time to time.