Patient Preauthorization Program Agreement

Dear Provider,

Your patients ("Patients") are referred to Houston Methodist ("HM") for imaging/ambulatory services. As a convenience to the Patients, HM would like to offer preauthorization to determine their insurability for these services. Third party payors typically require authorization from a referring physician for a representative to provide this pre-certifying service for Patients. In addition, HM may delegate pre-certification of your patients' services to another entity on its behalf.

If you want HM to pre-certify your Patients' insurability, please indicate your agreement for HM to communicate with third party payors regarding the Patient by signing where indicated below. After signature, please return it to the undersigned.

Thank you for your cooperation in this matter as we strive to provide the highest level of service to our patients.

I, _____, _____, hereby authorize HM to discuss
Credentials

my patient with any-and-all third-party payors necessary to pre-certify Patient's insurability.

Please allow authorization for the following hospital campus:

- Houston Methodist

Provider Signature: _____, _____
Credentials

Date: _____

Provider Contact Information

The following information is needed to complete your practice's preauthorizations below:
(*please print clearly and complete one page per provider*)

- Provider Name: _____
- Practice Name: _____
- National Provider Identifier (NPI): _____
- Provider Transaction Access Number (*PTAN): _____
- Tax ID: _____
- Primary Office Address: _____
- Primary Office Telephone #: _____
- Primary Office Fax #: _____
- Primary Office Contact: _____
- Primary Contact Email: _____
- Preferred Communication Method (please circle): Phone / Fax / Email

Please email completed form to HMPreAuthEnrollment@houstonmethodist.org.

*Please refer to the following page for instructions regarding the PTAN number.