Authorization Request

Colonoscopy Screening Form

Utilization Review Department
Michigan Conference of Teamsters Welfare Fund
Phone: (313) 964-2400

Please fax back this completed form for a colonoscopy screening authorization with the supporting medical records to: (313) 496-2939. Please be advised that this request for authorization is only for patients under the age of 45 requesting a screening

Today's date: _____

Patient Name: _____ Contract #: _____

Patient Date of Birth: _____

Provider: _____

Address: _____

Phone: _____FAX: _____

Date of Scheduled Colonoscopy: _____

Primary Diagnosis: _____ICD10: _____

Other Diagnosis _____ICD10: _____

1) Have the patient's relatives been diagnosed with colorectal cancer or tubular adenoma? If yes, please list individual's relationship to the relative / and the age of the relative when they were diagnosed.

   _____

   _____

   _____

2) Has the patient been diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease?
   Age Diagnosed _____
3) Has the patient been diagnosed with sclerosing cholangitis? _____ Age Diagnosed _____
4) Has the patient been diagnosed with colorectal cancer? _____ Age Diagnosed _____
5) Has the patient been diagnosed with (pre-cancer) multiple polyps? _____ Age Diagnosed_____

-PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT-