

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-

PRIVACY NOTICE: This communication, including attachments, may include confidential and/or proprietary information, and may be used only the person or entity to which it is addressed. If the reader of this fax is not the intended recipient or his or her authorized agent, the reader is hereby notified that any dissemination, distribution or copying of this fax and attachments is prohibited. If you have received this fax in error please notify the sender by calling the above number and destroy this message and attachments immediately. Feb 2017.