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-

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