SouthernCare
Where caring is a way of life.

Authorization of Services

CONFIDENTIAL

Office Name: ______________________________ Patient ID#: ______________________

Patient Name: ______________________________ Date of Birth: ______________________

This patient is authorized for the following service(s) or is approved for the length of stay indicated below. If the services to be provided differ from those listed below, please notify the Clinical Director of SouthernCare prior to the procedure being performed or stay extension. The Clinical Director can be reached 24 hours a day, seven days a week at the phone number listed below.

Has Been Approved For *(description of services)*: ______________________________

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Date of Service: ____

Hospice Admission ICD Code: ____

IDG Approval Date: ____

AUTHORIZATION

If the service(s) to be provided are significantly different from those stated on this Authorization of Services, unless an emergency exists, please call the Clinical Director at ____________________ or ______________________ to discuss further approval.

All invoices must have the patient number referenced. Send invoices to:

Invoices received without the case number referenced may result in delay of payment.

Please direct billing questions to Accounts Payable at (205) 868-4476.

OBTAINING AUTHORIZATION DOES NOT GUARANTEE REIMBURSEMENT.

Performing services beyond the pre-certified list above may result in denial.