PROVIDER AUTHORIZATION FOR TRITON MEDICAL SOLUTIONS REPRESENTATIVE TO OBTAIN PRIOR AUTHORIZATION FOR ORDERED PROCEDURE

Date: _____

Patient Information	Provider Information
Member Name:	Name of Practice:
Insurance Company:	Name of Provider:
Member ID:	Address:
	Address 2:
	City, State, Zip:
	Tax ID:
	Billing NPI:

I hereby authorize Triton Medical Solutions to represent my practice in order to obtain prior authorization for my patient.

☐ I hereby authorize Triton Medical Solutions to represent my practice to obtain prior authorization for all future patients of issuing provider.

I understand that the information may be privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

X _____ _____

Signature of MD Date

If you have any questions about this form, please contact Dave Woods (602) 457-7320, Ext: 102

Please fax completed form to: (866) 972-5608 or have patient return completed form to issuing provider.