Pre-Authorization Form

If not a medical emergency as defined by your policy contract, you must wait until you have a written authorization from TSS Assist before proceeding with any procedure requiring pre-authorization. Otherwise, a penalty co-pay will be applied to your claims, and the provider may decline to direct bill us. Your policy has requirements regarding the pre-authorization of certain treatments/procedures. Non-emergency authorizations may take up to 5 business days to complete.

Please send the completed form to TSS Assist at:

- Email: Assist@TSSAssist.com
- Fax: +1.949.271.5038

A. PATIENT INFORMATION	
Name (Last, First, MI):	
Policy #:	Member ID #:
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	Employer (if applicable):
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	

B. PRE-AUTHORIZATION REQUEST
Procedure/treatment name:
Is the patient having surgery? ☐ Yes ☐ No If Yes, what type of anesthesia is required? ☐ Local ☐ General ☐ Or Sedation
Expected surgery/inpatient admission date (DD/MMM/YYYY):
Is the patient being admitted to the hospital overnight? ☐ Yes ☐ No If yes, expected number of days/durations:_____
MATERNITY ADMISSIONS ONLY – Anticipated type of delivery: ☐ Vaginal ☐ Cesarean Section
Estimated Physician/Surgeon Cost and Currency:
Estimated Hospital/Facility Cost and Currency:
First date injury, illness or accident occurred (DD/MMM/YYYY):
First date you ever received treatment for this condition (DD/MMM/YYYY):
Describe treatment(s) received for this condition, if any, including dates (ex: medicine, consultation, surgery, hospitalization and conservative treatments):

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Treatment resulting from:

a. The patient's occupation? ☐ Yes ☐ No b. An automobile accident? ☐ Yes ☐ No c. Any type of accident? ☐ Yes ☐ No
If yes to any of the above, please provide date and details of accident:

Has diagnosis/treatment for same or related condition been given previously? If so, provide dates, results, kind of treatment, prescriptions, name of doctor/facility: Is this patient also covered by:

a. Other Group Health/Dental plan(s)? ☐ Yes ☐ No

b. Medicare / other Government Agency? ☐ Yes ☐ No

c. No-fault auto carrier? ☐ Yes ☐ No

If yes to any of the above, please provide:

Name of Carrier: _____Policy number of other source: _____

Carrier Address: _____

C. HOSPITAL/PHYSICIAN INFORMATION

Hospital/Facility Name:	Tax ID Number (U.S. Hospitals only):
Physician/Provider Name:	Tax ID Number (U.S. Doctors only):
Address:	
Postal Code:	Country:
Phone:	Email:

D. AUTHORIZATION

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Name:	Date:

Signature:
By typing my name on this form, I am signing electronically, and this electronic signature is the legal equivalent of my manual, handwritten signature.

Privacy Notice

The Total Scholastic Solutions group of companies includes brokering and management companies, as well as assistance and administration companies. We respect your privacy, and we are all committed to protecting your personal information.

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at www.totalscholasticsolutions.com/privacy-policy and we would advise you to read the policy so you understand your rights and your personal data use by the TSS Group.