Northwood
Batch Authorization Request Form

Provider Name: **Northwood Provider Number:**

Date: **Provider Contact:** **Provider Phone:**

Member Name (LAST)	Member Name (FIRST)	Member ID #	Diagnosis Code(s) ICD9	HCPCS	Quantity	Frequency	RENTAL Original DOS	Ordering Physician Name & Phone Number	Previous Authorization # (if applicable) AND End Date	Northwood Use Only Authorization Outcome
EXAMPLE: Smith	John	123456789	327.23	E0601	1	11 (remaining rental months)	10/17/2014	Dr. Name, 603-555-1212	N67890000; 11/16/15	

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