

**STATE OF ALABAMA**  
**SEICTF (State Employee Injury Compensation Trust Fund)**  
**Pre-Authorization Form for Medical Procedures**  
Fax to SEICTF 888-827-6753 or 334-223-6170  
Phone 334.956.7114 or 800.388.3406 ext 114

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**ATTENTION: UR NURSE**  
**PLEASE COMPLETE ALL BLANKS**

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**WHO?**      **PATIENT'S NAME:** \_\_\_\_\_  
**Social Security No:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Date of Injury:** \_\_\_\_\_ **Claim No. (If known):** \_\_\_\_\_  
**Body part(s) injured/involved:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **SEX: M \_\_\_ F\_\_\_** **Phone Number:** \_\_\_\_\_

**WHAT?**  
**NAME OF PROCEDURE (CPT CODES IF SURGERY):** \_\_\_\_\_  
**FREQUENCY & DURATION (i.e. PT, ESI...)** \_\_\_\_\_

**WHEN?**      **DATE SCHEDULED:** \_\_\_\_\_

**WHERE?**      **FACILITY & CITY PROCEDURE WILL BE PERFORMED:** \_\_\_\_\_

**WHY?**      Symptoms, physical exam results, previous test results, current treatment plan, medications, any pre-existing conditions which may impact the injury and/or treatment.  
**(FAX THE LATEST CLINICAL INFORMATION TO SUBSTANTIATE THIS REQUEST)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**PLEASE PRINT THE FOLLOWING INFORMATION**

**Physician Ordering Procedure:** \_\_\_\_\_  
**Facility/Physician Group Name:** \_\_\_\_\_  
**Staff Member Making Request:** \_\_\_\_\_  
**Telephone Number:** (    ) \_\_\_\_\_ **Fax number:** \_\_\_\_\_  
**Preferred Method of Contact:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_  
**Faxed by:** \_\_\_\_\_ **Date Faxed:** \_\_\_\_\_

**BEST DATE/TIME TO CONTACT ORDERING PHYSICIAN FOR A PEER-TO-PEER DISCUSSION WITH PHYSICIAN**

**ADVISOR?** \_\_\_\_\_

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