



Colonoscopy Prior Authorization Request Form

Fax: 563-585-1545

Telephone: 563-584-3275 or 1-800-325-7442

Date: _____ Time: _____ Contact person _____
Telephone Number _____

Physician: _____
(May affix patient label for patient identification)

Patient Name: _____

Date of Birth: _____

Date of Service: _____

Facility: _____

Diagnosis and Dx code: _____

Please check all that apply:

First Colonoscopy _____ Yes _____ No

Colonoscopy at 10 yr interval _____ Yes _____ No Date of last Colonoscopy _____

_____ Personal History of Inflammatory Bowel Disease _____ Age of onset

_____ Left Colon involvement only

_____ Personal History of Colorectal Cancer (CRC)

_____ Family History of Colorectal Cancer (CRC)

- Please specify relationship to patient _____
- Date of onset of Family member's Colorectal Cancer (CRC) _____

Surveillance of polyps:

_____ large (>1cm in diameter) **or**

_____ Multiple Adenomatous polyps

_____ Family History of Hereditary Non-Polyposis Colon Cancer (HNPCC)

_____ Family History of Familial Adenomatous Polyposis (FAP)