Uxbridge Orthopedic & Sports Therapy

Authorization Requirements

For the Member Of:

Non PPO Blue Cross Blue Shield of Massachusetts
Non PPO Blue Cross Blue Shield of Rhode Island
Harvard Pilgrim
Workers Compensation
All **Out of Network** insurances.

Your insurance company is requesting authorization for services rendered here at Uxbridge Orthopedic & Sports Therapy.

My provider has informed me that my insurance company will not pay for these services until approval has been granted. I understand that I am responsible for all costs associated with the treatment that is provided to me, until authorization is approved.

Member Name: ____

Member ID Number: ____

Member/Guardian Signature: ______________________________ Date: __________________

Employee Witness: ______________________________ Date: __________________

Macintosh HD:Users:admin:Documents:Authorization Requirements Form.doc
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