PO Box 624, Tiffin, OH 44883
419.937.2540

PHYSICIAN AUTHORIZATION FOR SERVICES

Your patient, _____ has applied for services from our organization. We need the following questions answered before we can provide our services.

Is he/she currently a patient of yours _____Yes or _____No

Diagnosis Date:_____

Diagnosis: _____

_____

_____ _____

(Doctor Signature) (Date)