

## PATIENT PRECERTIFICATION AUTHORIZATION

I, \_\_\_\_\_, authorize my provider and health insurance plan, to disclose to The Pinnacle Health Group and/or their representatives, information about my medical condition, treatment, and insurance coverage (for example, my diagnosis, medical history, and insurance coverage limitations) as needed to authorize benefits for my procedure and determine if this procedure may be covered under the terms of my health insurance policy. Further, I consent to being contacted by The Pinnacle Health Group with respect to supporting the coverage for this procedure. I understand that I may refuse to sign this authorization and can revoke this authorization at any time, except to the extent that The Pinnacle Health Group has taken action in reliance on it, by mailing a written request to revoke this authorization to my insurance provider. I have read and understand this consent document:

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date