PRIOR AUTHORIZATION
REQUEST FORM

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Member Information			
Plan			
Member Name :		DOB :	Today's Date :
Member Id :		Member Phone Number :	
Service Type	☐ Elective/Routine	☐ Expedited/Urgent	

Clinical notes and supporting documentation are REQUIRED to review for medical necessity

Referal/Service type requested			
Inpatient ☐ ER Admits ☐ SNF ☐ Custodial ☐ Acute Impatient Rehab ☐ Inpatient Detox ☐ Ventilator Services	☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Speech Therapy ☐ Physical therapy ☐ Occupational Therapy	****Office** ☐ Office Procedure/Visit ****Home Health** ☐ Skilled Services ☐ Home Infusion	****DME** ☐ wheelchair ☐ Enteral Formula ☐ Prosthetic ☐ Other ☐ Out-of-State request

Procedure Information		
*Diagnosis Code & Description:		For Internal Use:
*CPT/HCPC Code & Description:		
*J Code/Description/Dose/NDC:		
*Number of visits/days/units requested (circle type and specific quantity):		
Dates of Service:	From: To:	

Requesting Provider Information		
*Name/Credentials:		
*Address:		Contact Name:
*Billing NPI:	*Phone No:	*Fax No:
*Billing TIN:		

Servicing Provider/Facility Information		
*Name:		
*Address:		Contact Name:
*Servicing NPI:	*Phone No:	*Fax No:
*Servicing TIN:		