

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

Referral/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:		