Prior Authorization Determination Template

Input Conditions:

Service Description: _____

Service Code(s): _____

Modifiers: Any ☐ Include ☐ Exclude ☐ List:_____

Patient Information:

Gender: Any ☐ Female ☐ Male ☐

Age: Any ☐ Age Range _____

Program: Any ☐ Include ☐ Exclude ☐
List: _____

Provider Information:

Provider Type: Any ☐ Include ☐ Exclude ☐

List: _____

Provider Specialty: Any ☐ Include ☐ Exclude ☐
List:_____

Place of Service Restrictions:

Any ☐ Inpatient ☐ Outpatient ☐ Office ☐ DME ☐ Lab ☐
Nursing Facility ☐ Telehealth ☐ Ambulatory Surgery ☐ Other ☐

Required Diagnosis: Any ☐

List _____

PA FHIR Coverage Information

Coverage:	PA Required: ☐	PA Not Required: ☐	Not Covered: ☐
May submit PA Request:	Referring ☐	Performing ☐	Either ☐
Documentation Type:	Administrative ☐	Clinical ☐	Both ☐
When submitted:	With PA ☐	With Claim ☐	Retain ☐

Information required to evaluate Prior Authorization Request

Required Clinical Observations / Data

-
-
-

Required Assessments

-
-
-

Required Evidence (notes, tests, x-rays)

-
-
-

Required Supporting Documentation

-
-
-