# 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**