Prior Authorization Form

Patient Information

- **Patient Name:** John Doe
- **Date of Birth:** 01/15/1985
- **Age:** 37
- **Gender:** Male
- **Address:** 123 Main Street, Anytown, USA
- **Phone Number:** (555) 123-4567
- **Insurance ID:** ABC123456
- **Policy Number:** POL987654

Healthcare Provider Information

- **Provider Name:** XYZ Medical Group
- **Provider ID:** 78901234
- **Address:** 456 Oak Avenue, Cityville, USA
- **Phone Number:** (555) 789-1234
- **Fax Number:** (555) 789-5678

Requested Service/Medication Information

- **Service/Procedure/Medication Name:** MRI Scan
- **CPT Code/HCPCS Code/NDC Code:** 72148
- **Date of Service:** 02/10/2024
- **Diagnosis Code:** M54.5
- **Duration of Treatment:** 02/10/2024 - 02/15/2024

Supporting Documentation

- Attach any relevant medical records, test results, or notes that support the medical necessity of the requested service or medication.

Justification for Prior Authorization

The patient, John Doe, requires an MRI scan (CPT code 72148) due to persistent back pain (Diagnosis code M54.5). Previous treatments have not provided significant relief, and the MRI is necessary for a more accurate diagnosis and treatment plan.

Certification and Signature

I certify that the information provided is accurate and complete to the best of my knowledge.

- **Provider's Name:** Dr. Jane Smith
- **Date:** 01/25/2024

Note: This is a fictional example with random data for illustration purposes. In a real-world scenario, ensure that accurate and relevant information is provided on the Prior Authorization form.