Prior Authorization Request Form

Patient Information

- **Patient Name:** John Doe
- **Date of Birth:** 01/15/1985
- **Insurance ID:** ABC123456

Healthcare Provider Information

- **Provider Name:** Medical Care Clinic
- **NPI (National Provider Identifier):** 1234567890

Request Details

- **Requested Medication/Service:** Acme Medication X
- **Dosage/Duration:** 10mg, 30 days
- **Medical Justification:** Patient has been diagnosed with Condition Y, and Medication X is the recommended treatment according to recent test results.

Supporting Documentation

Attach any relevant medical records, test results, or documentation supporting the need for prior authorization.

Acknowledgment and Consent

I, the undersigned, acknowledge that the information provided in this form is accurate and complete to the best of my knowledge. I understand that the prior authorization process is subject to approval by the insurance company, and I consent to the release of medical information as necessary for this process.

Patient's Signature: _____

Date: 01/20/2024

Please submit this form to the insurance company for prior authorization. For any questions, contact the healthcare provider or insurance company directly.