MEDICAL MUTUAL®

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Prior Approval Form

Please print with black ink or fill in using Adobe® Reader®. For a list of medications and services requiring prior approval or considered investigational, visit the Tools & Resources, Care Management, Prior Approval & Investigational Services Resources section of Provider.MedMutual.com.

Date:_____

Patient Information

Patient Name (Last, First)		Date of Birth (mm/dd/yyyy)
Mailing Address (Street, City, State & Zip)		
Identification No.	Daytime Phone	Group No.

Provider Information

Provider Name (Last, First)		NPI No.
Mailing Address (Street, City, State & Zip)		Phone Number
Requester/Title (if different than prescriber)		Phone Number
Provider Signature		Date

For Genetic Testing — Lab Performing Test

Provider Name	NPI No.	Z Code
Mailing Address (Street, City, State & Zip)		Phone No.

Reason for Prior Approval

❑ Procedure ❑ Durable Medical Equipment (DME) ❑ Device ❑ Medication—Injectable and Infusion (Complete Medication Prior Approval section only)
❑ Genetic Test ❑ Other—Describe

Description of Service (Please specify exact services being requested.)

Diagnosis

ICD-10-CM Diagnosis Code(s)

Is this an established diagnosis for the patient? ❑ Yes ❑ No

CPT/HCPCS Code(s)

Name and place of service ❑ Office ❑ In/Outpatient Facility ❑ Home ❑ SNF ❑ Other—Describe

Is there previous history of services relating to this prior approval? ❑ Yes ❑ No If yes, please describe.

Medical Necessity Statement and Documentation

The following documentation is enclosed for review of this prior approval request...
❑ Office Notes ❑ Medical Records ❑ X-rays ❑ Photos ❑ Other—Describe

Medication Prior Approval — Please complete one form per medication being requested

Complete this form for an injectable or infusion being requested under the member's medical benefit, i.e., non self-administered injectables. If the medication is self-administered, contact the member's pharmacy benefit manager to determine prior authorization requirements.

Requested Medication

❑ New Request (Proceed to Diagnosis) ❑ Renewal of previous approval. If renewal, explain how efficacy has been determined.

Diagnosis

ICD-10-CM Diagnosis Code(s)

Weight (lbs.)	Height

Dose	Frequency	Route

CPT/HCPCS Code	NDC

Place of Service ❑ Office ❑ Outpatient Facility ❑ Infusion Center ❑ Pharmacy ❑ Other—Describe

Medical Necessity (clinical and treatment history). Include medications adverse effects and conditions.

The following documentation is enclosed for review of the prior approval request...
❑ Office Notes ❑ Medical Records ❑ Other—Describe

For Procedures, Durable Medical Equipment, Devices and Other Services, fax this form with the medical necessity documentation to (877) 321-6664 or mail to:

Medical Mutual of Ohio
Care Authorizations Department (MZ: 01-5B-3982)
2060 East Ninth Street
Cleveland, Ohio 44115-1355

Fax Medicare Advantage prior approval requests, for services other than medications, to (800) 221-2640.

Fax medication prior approval requests for Medicare Advantage and all other plans to Medical Drug Management at (866) 620-4028.