



Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
 All fields must be completed for the request to be processed.
 Please make a selection where applicable throughout the document.

DATE			
TYPE OF REQUEST	<input type="checkbox"/> URGENT	<input type="checkbox"/> STANDARD	<input type="checkbox"/> RETROSPECTIVE
TREATMENT SETTING	<input type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT	
REQUEST TYPE	<input type="checkbox"/> EXTENSION	<input type="checkbox"/> INITIAL	<input type="checkbox"/> CANCEL
	<input type="checkbox"/> ADDITIONAL CLINICAL	<input type="checkbox"/> DISCHARGE PLANNING	<input type="checkbox"/> CHANGES DOS/SETTING <input type="checkbox"/> OTHER
PREVIOUS AUTHORIZATION NUMBER			
CONTACT NAME			
CONTACT PHONE		CONTACT FAX	

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID (MEDICAID ID OR HEALTH PLAN ID)		
MEMBER PHONE NUMBER		DATE OF BIRTH
MEMBER STREET ADDRESS		
CITY	STATE	ZIP

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PROVIDER INFORMATION

PROVIDER NAME		
PROVIDER TIN	PROVIDER NPI	
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER	
PROVIDER STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <input type="checkbox"/> PAR <input type="checkbox"/> NON PAR <input type="checkbox"/> IN CREDENTIALING		
FACILITY NAME		
FACILITY TIN	FACILITY NPI	
FACILITY PHONE NUMBER	FACILITY FAX NUMBER	
FACILITY STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <input type="checkbox"/> PAR <input type="checkbox"/> NON PAR <input type="checkbox"/> IN CREDENTIALING		

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)		
REFERRING PHYSICIAN TIN		
REFERRING PHYSICIAN NPI		
REFERRING PHYSICIAN PHONE NUMBER		
REFERRING PHYSICIAN FAX NUMBER		
REFERRING PHYSICIAN STREET ADDRESS		
CITY	STATE	ZIP
PROVIDER STATUS <input type="checkbox"/> PAR <input type="checkbox"/> NON PAR <input type="checkbox"/> IN CREDENTIALING		



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MEDICAL SECTION

DIAGNOSIS CODE

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PROCEDURE CODE	START DATE	END DATE	NUMBER OF UNITS	CODE DESCRIPTION



MEDICAL SECTION

NOTES

PLEASE FAX TO **1-888-989-0019**

IN ORDER TO PROCESS YOUR REQUEST IN A TIMELY MANNER, PLEASE SUBMIT ANY PERTINENT CLINICAL INFORMATION TO SUPPORT THE REQUEST FOR SERVICES. IF AN OUT-OF-NETWORK PROVIDER IS BEING USED, PLEASE SUBMIT DOCUMENTATION TO SUBSTANTIATE THE USE OF AN OUT-OF-NETWORK PROVIDER AS WELL. PLEASE CONTACT OUR UTILIZATION MANAGEMENT DEPARTMENT AT **1-888-312-5713** WITH QUESTIONS.

URGENT MEDICAL CONDITION: ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.



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