AFFINITY MEDICAL GROUP

Fax: 855.220.1423
Provider Services: 800.615.0261

Prior Authorization Request Form

Please check type of request: ☐ Routine (Non-urgent services) ☐ Expedited (Medicare only—Care required within 72 hours)
☐ Urgent/Concurrent (Care required within 24 hours) ☐ Submission of additional clinical information

Patient Name:	DOB:	Daytime Phone:	
Health Plan:	Health Plan ID#:		
Address:	City:	State:	Zip:

Facility/Provider/Service Information:

Referring Provider:	☐ PCP ☐ SPEC	Phone:
Provider Signature:	Date:	Fax:

☐ Office ☐ Outpatient ☐ Inpatient Admit ☐ Diagnostics ☐ DME ☐ Home Health ☐ Injectables ☐ Other _____

Requested Provider/Facility:		**Requested Physician/Specialist:**
Name:	First Name:	Last Name:
Address:	Phone:	Fax:

Requested Service(s):

REQUIRED:
ICD10 Code(s)
CPT Codes(s)

Diagnosis/Clinical Problem:

Clinical History/Date of Onset:

Prior Treatment:

Relevant Diagnostic Testing:

Form Submitted by: _____ Date _____ Phone: _____

THIS AUTHORIZATION IS BASED ON ELIGIBILITY AT TIME THE SERVICES ARE RENDERED.