



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:		<input type="checkbox"/> PCP <input type="checkbox"/> SPEC	Phone:	
Provider Signature:		Date:	Fax:	
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Admit <input type="checkbox"/> Diagnostics <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Injectables <input type="checkbox"/> 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.

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