



Fax: 855-220-1423  
 Provider Services: 800-615-0261

## Prior Authorization Request Form

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

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

**Facility/Provider/Service Information:**

Requested By Provider:	<input type="checkbox"/> PCP	<input type="checkbox"/> SPEC	Phone:
Provider Signature:	Fax:		

Office  Outpatient  Inpatient Admit/SNF  Diagnostics  DME  Home Health  Injectables  Other \_\_\_\_\_

<b>Referring to Provider/Facility:</b>	<b>Referring to Physician/Specialist:</b>
<b>Referring to Provider TIN:</b>	<b>Referring to Provider NPI:</b>
<b>Referring to Provider Address:</b>	<b>Phone:</b>
	<b>Fax:</b>

REQUIRED: CPT Code(s)	Quantity	ICD-10 Code(s)

**REQUIRED:** Please submit supporting clinical documentation of the following:  
 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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