



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:
<b>Facility/Provider/Service Information:</b>		
Requested By Provider:	<input type="checkbox"/> PCP <input type="checkbox"/> SPEC	Phone:
Provider Signature:	Fax:	
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Admit/SNF <input type="checkbox"/> Diagnostics <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Injectables <input type="checkbox"/> 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>	
	<b>If Referred to Provider is Out of Network, Permission to redirect In-Network? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>	
<b>REQUIRED: CPT Code(s)</b>	<b>Quantity</b>	<b>ICD-10 Code(s)</b>
<b>REQUIRED:</b> 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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