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) 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: ❑ PCP ❑ SPEC Phone:

Provider Signature: Fax:

❑ Office ❑ Outpatient ❑ Inpatient Admit/SNF ❑ Diagnostics ❑ DME ❑ Home Health ❑ Injectables ❑ Other _____

Referring to Provider/Facility:	**Referring to Physician/Specialist:**
Referring to Provider TIN:	**Referring to Provider NPI:**
	Phone:
Referring to Provider Address:	**Fax:**
	If Referred to Provider is Out of Network, Permission to redirect In-Network? ❑ Yes ❑ No

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.