PRIOR AUTHORIZATION REQUEST

Each field must be completed.

Incomplete documentation will be returned to referring provider

Fax completed form to: 833-523-2627

☐ **Inpatient**	☐ **Ambulatory / Outpatient**		
MEMBER INFORMATION:			
Member Name & DOB:		Identification Number:	Referring Date:
Member Address:		Member Phone Number:	
ORDERING PHYSICIAN INFORMATION:			
Referring Physician:		Phone Number:	Fax Number:
Referring Physician's Address:		**Referring Physician's Signature/License Number:**	
TIN/NPI:	**Location Code:**		
RENDERING PHYSICIAN/FACILITY INFORMATION:			
Refer to (Provider Name):		Refer to (Facility Name):	
Refer to (Provider Address):		Refer to (Facility Address):	
Contact Person:	Specialty:		
Phone Number:	Fax Number:	Phone Number:	Fax Number:
TIN/NPI:	**Location Code:**	**TIN/NPI:**	**Location Code:**

REQUESTED SERVICE/PROCEDURE/COURSE OF TREATMENT

POS: ☐ Outpatient Center ☐ Inpatient Hospital ☐ SNF/Rehab ☐ Home ☐ Hospice ☐ Office ☐ Inpatient Psychiatric Facility ☐ Other

If Other, please specify:

Type of Service:	☐ Initial ☐ Extension - Previous Authorization #

If inpatient,
Estimated length of stay:
Tentative discharge plan information:

Units/Volume/Visits Requested:	Frequency/Length of Time:

HCPCS/CPT CODES:

Latest ICD Code:	HCPCS/CPT Code:	Code Description:	Medical Reason:

IMPORTANT INFORMATION:

Please include/attach clinical/office notes, laboratory information, imaging reports, and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.

☐ **Check box if physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.**

Telephone: 833-991-9909 Fax: 833-523-2627 Rev. 02/14/19

FOR MEDICATIONS THAT REQUIRE AUTHORIZATION,
FAX COMPLETED FORM TO THE PHARMACY DEPARTMENT: 833-523-2630