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 /**

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

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