



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

Prior Authorization Request Form

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

Patient Name:	DOB:	Daytime Phone:	
Health Plan:	Health Plan ID#:		
Address:	City:	State:	Zip:
Facility/Provider/Service Information:			
Referring Provider:	<input type="checkbox"/> PCP <input type="checkbox"/> SPEC	Phone:	
Provider Signature:	Date:	Fax:	
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient Admit <input type="checkbox"/> Diagnostics <input type="checkbox"/> DME <input type="checkbox"/> Home Health <input type="checkbox"/> Injectables <input type="checkbox"/> Other _____			
Requested Provider/Facility:		Requested Physician/Specialist:	
Name:	First Name:	Last Name:	
Address:	Phone:	Fax:	
Requested Service(s):	REQUIRED:		
	ICD10 Code(s)		
	CPT Codes(s)		
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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