

## Medical Prior Authorization Request Form

Please check type of request:  Routine (Non-urgent services)  Expedited (Care required within 24 hours —must meet Medicare expedited criteria)  Submission of additional clinical information (include reference #)

Patient Name:		DOB:	Daytime Phone:
Health Plan:		Health Plan ID#:	
Address:		City:	State: Zip:
<b>Facility/Provider/Service Information: REQUIRED (ALL)</b>			
Referring Provider:		<input type="checkbox"/> PCP <input type="checkbox"/> SPEC	Phone: (REQUIRED)
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 _____			
<b>Requested Provider/Facility:</b>		<b>Requested Physician/Specialist:</b>	
Name:		First Name:	Last Name:
Address:		Phone:	Fax:
Requested Service(s):		<b>REQUIRED:</b>	
		ICD-10 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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