



Prior Authorization Form
 Please Fax All Requests to: 866-293-9665
 Please Attach Supporting Clinical Documentation

MEMBER INFORMATION				
Name:	Date of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Member ID#:	Primary Insurance:	Other Insurance (TPL, Workers' Comp):		
Address:		Phone Number:		
Date & Place of Injury (if applicable):				
REFERRING/ORDERING PROVIDER INFORMATION				
Name:	NPI#:	Tax ID#:		
Address:				
Name of Contact Person:	Phone:	Fax:		
TREATING SPECIALIST/FACILITY INFORMATION				
Name:	NPI#:	Tax ID#:		
Address:				
Name of Contact Person:	Phone:	Fax:		
REQUESTED SERVICE(S)				
Service(s) Requested:		# of Treatments/Items Requested:		
Diagnosis:	ICD-10 Code(s):			
CPT, HCPC or J-Code(s): Please include units per code, purchase/rental price for DME, and dosage amounts for medications				
Place of Service (choose one): <input type="checkbox"/> Office <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Other				
Requested Date(s) of Service:		Service(s) Rendered: <input type="checkbox"/> Yes <input type="checkbox"/> No Pending Authorization: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Prior authorization is based on the medical necessity of the services requested. Actual benefit payment is contingent upon eligibility, benefits available at the time service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, as well as other provisions of the medical plan.

The information contained in this form, including attachments, is privileged & confidential, and is only for the use of the individuals or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible for delivering it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify the sender immediately and shall destroy all information received.

PLEASE NOTE: ALL ABOVE SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL IN ORDER FOR REQUEST FOR PRIOR AUTHORIZATION TO BE ACCEPTED FOR REVIEW.

ALL CLINICAL NOTES AND/OR ORDERS ONLY ACCEPTED FROM MD, NP, FNP, AND APRN.