Prior Authorization Request Form

Patient Information

Name (First, MI, Last):	DOB:	Gender:	Member ID Number:
Address:			
Patient E-mail Address:	Telephone Number:		
Employer/Group Name:		Employer/Group Number:	

Provider Information (Requesting/Servicing)

Requesting Physician:	Phone Number & Extension:	Fax Number:
Address:	NPI Number:	Tax ID Number:
Servicing Facility (where services will be rendered):	Phone Number & Extension:	Fax Number:
Address:	NPI Number:	Tax ID Number:

Contact Name (person completing this form):	Phone Number & Extension:	Are you with Requesting or Servicing provider:

Authorization Request Information

Case Type	☐ Inpatient	☐ Outpatient
Medical, Surgical, Obstetrics, MH, SA, Diagnostic, Continuing Care		
Urgency	☐ Elective	☐ Urgent
Date(s) of Service	Medical Record #:	

REQUIRED FOR ALL REQUESTS: ICD-10 Code(s) & Description

REQUIRED FOR ALL PROCEDURES/DIAGNOSTICS: CPT Codes(s), description, Date

Description of symptoms:
Prior treatment provided (i.e., PT, NSAIDS):
Related labs/diagnostic studies results (i.e., X-rays, ultrasound labs):

Benefits are subject to eligibility and plan policy provisions at the time services are incurred.

Send completed form and supplemental clinical via fax to (866) 881-9643.

Please note - Case will not be initiated without completed form and supplemental clinical.