

Prior Authorization Form

Please Check Type: ☐ Expedited / Urgent ☐ Standard / Routine

Line of Business: ☐ Medicare ☐ Medi-Cal ☐ D-SNP

Name of Person Submitting Authorization:

Date of Submission:

Member Information: (Must complete in full)

Patient Name:

DOB:

Age:

Address:

Daytime Phone:

Member ID#

Alternate ID/Other Coverage:

Requesting Provider Information: (Must complete in full)

Requesting Provider:

Address:

Phone:

Fax:

Provider NPI #

Tax ID #

Provider Signature:

Date:

Requested Service(s) (Must complete in full)

ICD10 Code(s):

CPT Code(s)

Requested Specialty:

Place of Service: ☐ Office ☐ Outpatient ☐ Inpatient

Requested Unit(s)

☐ Ambulatory Surgery Center ☐ Other

Clinical History / Date of Onset:

Requested / Servicing Provider and Facility Information: (Must complete in full)

Requested Provider:

Address:

Requested Provider Phone:

Fax:

Requested Provider NPI #

Tax ID #

Requested Facility:

Address:

Facility Phone:

Fax:

Facility NPI#:

Tax ID #:

To process this request, please attach clinical documentation including progress notes, reports, labs, imaging, etc.
(Total additional pages _____)

CONFIDENTIALITY NOTICE: This communication contains information intended for the use of the individuals to whom it is addressed and may contain information that is privileged, confidential or exempt from other disclosure under applicable law. If you are not the intended recipient, you are notified that any disclosure, printing, copying, distribution or use of the contents is prohibited. If you have received this in error, please notify the sender immediately by telephone or by returning it by return mail and then permanently delete the communication from your system. Thank you