HealthPlans
A HARVARD PILGRIM COMPANY

Care Management Services
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Prior Authorization Request Form

** * * Please include clinical documentation to support your request * * **

Member ID#_____ Patient's Name_____

Patient's Date of Birth_____ Patient's Phone#_____

Hospital/Facility Name_____ Tax ID#_____

Facility Address_____

_____

_____

Facility Phone#_____ Utilization Dept. Phone#_____

Treating Physician's Name_____ Tax ID#_____

Physician's Address_____

_____

_____ Phone#_____

Date of Procedure_____ *Please check one:* ☐ Inpatient ***or*** ☐ Outpatient

Diagnosis_____

_____ ICD-9 Code(s)_____

Procedure(s)_____

_____ CPT/HCHP Code(s)_____

DISCLAIMER

Consideration of this request is based upon current information submitted for review. A case number does not guarantee payment; claims payment is dependent on the patient's eligibility at the time services are rendered, the patient's benefits as stated in the plan document, retrospective review of clinical data, and the required documentation of the service(s) provided.

Sender's Name:_____ Phone#:_____ Ext:_____

CONFIDENTIALITY NOTICE