

**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: \_\_\_\_\_

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