

SECTION I: SUBMISSION AND HEALTH PLAN INFORMATION				
Health Plan:	Plan Fax #:	Phone:	Date Form Completed and Faxed:	
SECTION II: SUBMISSION TYPE				
Review Type: <input type="checkbox"/> Urgent <input type="checkbox"/> Standard		Clinical Reason for Urgency:		
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Reauthorization/Concurrent Review*			* Previous Auth #:	
SECTION III: PROVIDER INFORMATION				
Requesting Provider or Facility:	NPI #:	TIN:	Phone:	Fax:
Requesting Provider's Signature (if applicable):			Date:	
Servicing Provider Name:	NPI #:	TIN:	Phone:	Fax:
Servicing Facility Name:	NPI #:	TIN:	Phone:	Fax:
Primary Care Provider Name:			Fax #:	
Contact Person:	Phone:	Fax:	Email:	
SECTION VI: PATIENT INFORMATION				
Name:	Phone:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Subscriber Name (if different):	Member ID #:	Group #:		
Address:		Phone:		
SECTION VII: SERVICES TO BE AUTHORIZED <i>(check all that apply)</i>				
<b>Ambulatory/outpatient</b> <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Infusion <input type="checkbox"/> Medication <input type="checkbox"/> Oral surgery <input type="checkbox"/> Surgery/procedure	<b>Outpatient Therapy</b> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Behavioral Therapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Pulmonary/Cardiac Rehab <input type="checkbox"/> ST		<b>Home Health/Hospice</b> <input type="checkbox"/> Skilled nursing <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Infusion	
<b>Radiology</b> <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> TEE <input type="checkbox"/> CTA <input type="checkbox"/> MUGA <input type="checkbox"/> TTE <input type="checkbox"/> MPI <input type="checkbox"/> PET <input type="checkbox"/> MRA <input type="checkbox"/> Stress Echo	<b>Durable Medical Equipment</b> <input type="checkbox"/> Orthodontics & prosthetics <input type="checkbox"/> Oxygen <input type="checkbox"/> PERS <div style="margin-left: 40px;"> <input type="checkbox"/> Purchase  <input type="checkbox"/> Rental           </div>		<b>Inpatient care/observation</b> <input type="checkbox"/> Acute medical/surgical <input type="checkbox"/> Acute rehab <input type="checkbox"/> Long-term acute care <input type="checkbox"/> Observation <input type="checkbox"/> Urgent <input type="checkbox"/> Skilled Nursing Facility	
Other – please specify:				
Explanation for medical necessity and reasonableness:				

**SECTION VIII: DIAGNOSIS/PLANNED PROCEDURE INFORMATION****Principal Diagnosis Description:****ICD-10 Code:****Secondary Diagnosis Description:****ICD-10 Code:**

<b>Service or Procedure</b>	<b>Code (CPT/HCPCS/REV)</b>	<b>Code/diagnosis Description</b>	<b>Frequency <sup>1</sup></b>	<b>Total Units</b>	<b>Unit Type <sup>2</sup></b>	<b>Start Date</b>	<b>End Date</b>

**Provider/Clinical Notes:****SECTION IX: CLINICAL DOCUMENTATION (SEE INSTRUCTIONS)**

**INSTRUCTIONS:** Give a brief narrative of medical necessity in this space, or in an attached statement. Attach supporting clinical documentation (e.g., medical records, progress notes, lab reports, discharge summary, etc.)

**MEDICAL NECESSITY CRITERIA:**

☐ By checking this box, I confirm that I am attaching supporting clinical documents with this Prior Authorization Request.

<sup>1</sup> Frequency includes per week, per month, etc.

<sup>2</sup> Unit Types include: Units, Visits, Days, Hours