SECTION I: SUBMISSION AND HEALTH PLAN INFORMATION

Health Plan:	**Plan Fax #:**	**Phone:**	**Date Form Completed and Faxed:**

SECTION II: SUBMISSON TYPE

Review Type: ☐ Urgent ☐ Standard	**Clinical Reason for Urgency:**
Request Type: ☐ Initial Request ☐ 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:**	☐ Male ☐ Female ☐ Unknown ☐ Other
Subscriber Name (if different):	**Member ID #:**	**Group #:**	
Address:		**Phone:**	

SECTION VII: SERVICES TO BE AUTHORIZED *(check all that apply)*

Ambulatory/outpatient	**Outpatient Therapy**	**Home Health/Hospice**
☐ Genetic Testing ☐ Infusion ☐ Medication ☐ Oral surgery ☐ Surgery/procedure	☐ Acupuncture ☐ Behavioral Therapy ☐ Chiropractic ☐ OT ☐ PT ☐ Pulmonary/Cardiac Rehab ☐ ST	☐ Skilled nursing ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA ☐ Infusion
Radiology ☐ CT ☐ MRI ☐ TEE ☐ CTA ☐ MUGA ☐ TTE ☐ MPI ☐ PET ☐ MRA ☐ Stress Echo	**Durable Medical Equipment** ☐ Orthodontics & prosthetics ☐ Oxygen ☐ PERS ☐ Purchase ☐ Rental	**Inpatient care/observation** ☐ Acute medical/surgical ☐ Acute rehab ☐ Long-term acute care ☐ Observation ☐ Urgent ☐ 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:**

Service or Procedure	Code (CPT/HCPCS/REV)	Code/diagnosis Description	Frequency [1]	Total Units	Unit Type [2]	Start Date	End Date

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.**

[1] Frequency includes per week, per month, etc.

[2] Unit Types include: Units, Visits, Days, Hours