PRIOR AUTHORIZATION FAX REQUEST FORM

Fax completed request to: (866) 370-5667
If you need assistance please call: (800) 865-5922

*Required Fields

TODAY'S DATE: _____ **SCHEDULED DATE OF SERVICE:** _____

***CONTACT NAME:** _____

***CONTACT PHONE:** _____ ***CONTACT FAX:** _____

PROVIDER INFORMATION

*Provider Name: _____

Provider NPI: _____ Provider TIN: _____

Provider Address: _____

FACILITY INFORMATION

Facility Name: _____

Facility NPI: _____ Facility TIN: _____

Facility Address: _____

MEMBER INFORMATION

*Member Name: _____ Member Phone: _____

*Member DOB: _____ *Member ID: _____

SERVICE INFORMATION

Service is: ☐ Initial Request ☐ Updated Request ☐ Medically Emergent (Needed within 72 hours)
☐ Inpatient ☐ Outpatient

If this is Workman's Compensation, list name of Employer. _____

If this is related to an MVA, list name of Company. _____

*ICD 10 Codes: CPT/HCPCS Codes:

_____ _____

CLINICAL INFORMATION

Please provide comments/clinical/supporting information to expedite the authorization:
Or See attached ☐

Requestor Signature (Required): X