



PRIOR AUTHORIZATION REQUEST FORM
 Prior Authorization Department Contact # – 1-866-543-2167
 Prior Authorization Department Fax # - 1-866-543-2184

***If your request for authorization is urgent or requires expedited review, please call 1-866-543-2167. Emergency services do not require authorization, however, notification requirements apply. Authorization is not a guarantee of payment.**

MEMBER INFORMATION	
Name:	Member ID#:
DOB:	PCP Name:
Gender (circle one): M or F	Other Insurance:

REFERRING PHYSICIAN &/OR PROVIDER INFORMATION	
Referring/Requesting Provider:	Consulting Provider/Facility:
Name:	Name:
Address:	Address:
Tel:	Tel:
Fax:	Fax:
Contact Person:	Specialty:
Physician Signature:	

REFERRAL/AUTHORIZATION INFORMATION	
Problem/Diagnosis (ICD-9 Code(s) Required*):	
Procedure/Injectable/Test Requested (CPT Code (s) Required*):	
Date of Appointment/Service:	# of Visits Required:
Type of Procedure (circle one):	Inpatient Outpatient In Office
Other Clinical Information (Include Clinical Notes, Labs, X-Ray Reports, etc.) – For Procedures, Please Attach Additional Pages as Necessary:	

***PLEASE NOTE: FAILURE TO INCLUDE CORRECT ICD-9, CPT CODES OR NOTES MAY RESULT IN THE RETURN OF THIS FORM UNPROCESSED**

For Administrative Purposes Only:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied Date:
Reason for Denial:	