



MEDICAL PRIOR AUTHORIZATION REQUEST FORM

Fax completed form to 888-888-8888

Questions? Call 888-888-8888

All fields are required - Incomplete forms will cause delays

Patient Information

Table with 4 columns: First Name, Last Name, Member ID, Date of Birth

Provider Information

Table with 4 columns: Provider Name, NPI #, Phone, Contact, Street Address, City, State, Zip Code

Diagnosis Code(s) and Procedure Code(s) table with ICD Code, Description, CPT or HCPCS Code, and Description columns

Planned date of service table

Please attach any additional information that may be important for this review ((chart notes, diagnostic tests, lab values when appropriate)

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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An authorization does not guarantee coverage and does not supersede and member benefit limits