PRIOR AUTHORIZATION REQUEST FORM

Fax completed form and supportive clinical to: **(305) 718-2868**

MEMBER INFORMATION:			
Member Name & DOB:		Member Identification Number:	Date:
Member Address:		Member Phone Number:	
REQUESTING PHYSICIAN INFORMATION:			
Referring Physician:		Phone Number:	Fax Number:
Referring Physician's Address:		**Referring Physician's Signature/License Number:**	
TIN/NPI:	**Location Code:**		
SERVICING PHYSICIAN/FACILITY INFORMATION:			
Servicing Provider Name:		Facility Name:	
Servicing Provider Address:		Facility Address:	
Contact Person:	Specialty:		
Phone Number:	Fax Number:	Phone Number:	Fax Number:
TIN/NPI:	**Location Code:**	**TIN/NPI:**	**Location Code:**

REQUESTED SERVICE/PROCEDURE/COURSE OF TREATMENT	
POS: □ Office □ Outpatient Center □ Outpatient Hospital □ Ambulatory Surgical Center □ Inpatient Hospital □ Inpatient Rehab □ SNF/Rehab □ Home □ Hospice □ Inpatient Psychiatric Facility □ Other	
If Other, please specify:	
Type of Service or Procedure:	□ Initial □ Extension - Previous Authorization #
Quantity or Number of Visits Requested:	

HCPCS/CPT CODES:			
Diagnosis ICD 10 Code:	HCPCS/CPT Code:	Code Description:	Medical Reason:

IMPORTANT INFORMATION:

Please include/attach clinical/office notes, laboratory information, imaging reports, and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.

□ **Check box if physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.**

Telephone: 844-969-5366 Fax: 305-718-2868