

# Prior Authorization Provider Request Form

Fax Requests to 1-844-306-1163

First Name	Last Name	Middle Initial
Member ID	Date of Birth / /	Phone Number ( )

Urgent  
 Standard

**Please select service(s) for which you are requesting prior authorization.**

<input type="checkbox"/> Home	<input type="checkbox"/> Office
<input type="checkbox"/> Ambulatory Surgical	<input type="checkbox"/> Off Campus Outpatient Hospital
<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> On Campus

**Please select where the drug will be dispensed**

Office  
 Outpatient Hospital  
 Pharmacy

Requesting Provider First Name / Last Name	NPI	TIN
Contact Person	Phone Number ( )	Fax ( )
Servicing Provider / Facility Name	NPI	TIN
Phone Number ( )	Fax ( )	
Start Date / /	Frequency	

**Applicable Diagnoses & ICD-10 Codes**

**Service Description and Code(s)**

**Medical Rationale for Request**

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