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.

- ❑ Home
- ❑ Ambulatory Surgical
- ❑ Inpatient Hospital
- ❑ Office
- ❑ Off Campus Outpatient Hospital
- ❑ 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