

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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