Authorization Number: ____________________
(Valid for 90 days from date of request)

PRIOR AUTHORIZATION REQUEST

FAX TO: 1-866-440-4628

☐ **STANDARD** ☐ **EXPEDITED** (Select expedited **ONLY** if the member's life, health or ability to regain maximum function is jeopardized.) *Do not use this form for authorizations that need immediate response (urgent). Please call 1-866-773-1072*

MEMBER INFORMATION

Member ID: ____________________ Request Date: ___ / ___ / _____

Member Last Name: ____________________ Member First Name: ____________________

Member Phone Number: _____ - _____ - ________ Date of Birth: ___ / ___ / _____ County: ____________

REQUESTING PROVIDER

Provider ID#: ____________________ Type: ☐ PCP ☐ Specialist *

Provider Last Name: ____________________ Provider First Name: ____________________

Phone Number: _____ - _____ - ________ Fax Number: _____ - _____ - ________

Contact Name: ____________________ ***Has PCP approved this request?** ☐ Yes ☐ No ☐ I am the PCP

(Failure to answer this question will delay the request. The response to this question is subject to audit of the PCP medical record for accuracy in accordance with your PUP Provider Contract.)

TREATING PROVIDER

Type: ☐ In Network ☐ Out-Of-Network ☐ Transition of Care

Provider ID#: ____________________ Specialty: ____________________

Provider Last Name: ____________________ Provider First Name: ____________________

Address: ____________________ City: ________ State: ________ Zip Code: ________

Phone Number: _____ - _____ - ________ Fax Number: _____ - _____ - ________ County: ____________

FACILITY

Type: ☐ OP Hospital ☐ Hospital ☐ Radiation Therapy ☐ Dialysis ☐ Free Standing Facility
☐ Rehab Facility ☐ Hospice ☐ Transition of Care ☐ Office ☐ Out-Of-Network ☐ SNF

Facility ID: ____________________ Facility Name: ____________________

Address: ____________________ City: ________ State: ________ Zip Code: ________

Phone Number: _____ - _____ - ________ Fax Number: _____ - _____ - ________ County: ____________

NOTIFICATIONS

☐ Unplanned Hospitalizations ☐ Observations ☐ Dialysis ☐ Hospice

INPATIENT ADMISSIONS

☐ Elective Hospital ☐ Skilled Nursing Admissions ☐ Rehabilitation Facility Admissions

SERVICES REQUESTED

Planned Date of Service: From: ______ / ______ / ________ To: ______ / ______ / ________

Primary ICD-9 Code: ____________________ Description:** ____________________

CPT-4 /HCPC Code**	Description of Procedure, Service**	Visits/Frequency**

***Please include additional procedure codes as may be applicable in the Clinical Summary below. This request cannot be processed without supporting clinical documentation, e.g., office visit notes, pertinent laboratory data, prior treatment(s.), note(s), etc.*

____

____

Authorization will be given for medically necessary services only. Receipt of authorization number does not guarantee reimbursement. Reimbursement is subject to benefit coverage and member eligibility at the time service is rendered.

11/18/09