

Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THE "STANDARDIZED PRIOR AUTHORIZATION FORM".
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.
The Standardized Prior Authorization Form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements. For payer specific policies, please reference the payer specific websites.

Health Plan:		Health Plan Fax #:	*Date Form Completed and Faxed:
Service Type Requiring Authorization^{1, 2, 3} (Check all that apply)			
Ambulatory/Outpatient Services <input type="checkbox"/> Surgery/Procedure (SDC) <input type="checkbox"/> Infusion or Oncology Drugs	Ancillary <input type="checkbox"/> Acupuncture <input type="checkbox"/> Chiropractic <input type="checkbox"/> IVF/ART <input type="checkbox"/> Non-Participating Specialist	Dental <input type="checkbox"/> Adjunctive Dental Services <input type="checkbox"/> Endodontics <input type="checkbox"/> Maxillofacial Prosthetics <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Restorative	Durable Medical Equipment <input type="checkbox"/> Prosthetic Device <input type="checkbox"/> Purchase <input type="checkbox"/> Renal Supplies <input type="checkbox"/> Rental
Home Health/Hospice <input type="checkbox"/> Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) <input type="checkbox"/> Hospice <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Respite Care	Inpatient Care/Observation <input type="checkbox"/> Acute Medical/Surgical <input type="checkbox"/> Long Term Acute Care <input type="checkbox"/> Acute Rehab <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Observation	Nutrition/Counseling <input type="checkbox"/> Counseling <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Infant Formula <input type="checkbox"/> Total Parental Nutrition	Outpatient Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Pulmonary/Cardiac Rehab <input type="checkbox"/> Speech Therapy
Transportation <input type="checkbox"/> Non-emergent Ground <input type="checkbox"/> Non-emergent Air	<input type="checkbox"/> Other—please specify:		
Provider Information (*Denotes required field)			
*Requesting Provider Name and NPI#:		*Phone:	Fax:
*Servicing Provider Name and NPI# (and Tax ID if required): <input type="checkbox"/> <i>Same as Requesting Provider</i>		*Phone:	Fax:
*Servicing Facility Name and NPI#: <input type="checkbox"/> <i>Same as Requesting Provider</i>		*Phone:	Fax:
*Contact Person:		*Phone:	Fax:
Member Information (*Denotes required field)			
*Patient Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female	*DOB:
*Health Insurance ID#: <i>If other insurance, please specify:</i>		*Patient Account/Control Number:	
Address:		Phone:	
Diagnosis/Planned Procedure Information (*Denotes required field)			
*Principal Diagnosis Description:		*Principal Planned Procedure (Description and CPT/HCPCS Code):	
ICD-9 Codes:		# of Units Being Requested: <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Visits <input type="checkbox"/> Dosage	
Secondary Diagnosis Description:		Secondary Planned Procedure (Description and CPT/HCPCS Code):	
ICD-9 Codes:		# of Units Being Requested: <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Visits <input type="checkbox"/> Dosage	
*Service Start Date:		*Service End Date:	

¹ Please attach plan specific templates that are required for supporting clinical documentation.

² Not all services listed will be covered by the benefits in a member's health plan product.

³ This form does not replace payer specific prior authorization requirements.