Completing the Medical/Surgical Prior Authorization Request Form

Do not bypass the *Instructions for Completion (*shaded area) at the top of the Prior Authorization form. These instructions summarize the most important components needed for your request to be processed:

1. Please print clearly
2. Complete all boxes marked with an * --if not completed, request will be returned.
3. Attach any clinical notes, lab results, imaging results, etc., to support your request.

There are three non * areas that are useful to the Health Plan in understanding your intent:

1. Requires (2nd Health Plan name) PA also? If that Plan is one we also manage, mark this box. It is helpful to enter that Plan ID # in the 'Other Insurance ID' field.
2. Is Request Medically Urgent? If so, mark the box at top right of the form.
3. Is Request being done retroactively? If so, mark "Retro Request" on upper right portion of form.

Completion of the * fields ensures that your request begins processing on arrival at the Plan, without a return trip to your office for completion of missing information:

1. ***Date—**Use today's date;
2. ***Office Contact person—**List the name of the person we should call if we have questions regarding this request;
3. ***Phone #--** List the phone number for the contact in the previous field;
4. ***Fax #--**The fax information you enter is used to fax the approval/denial information to the correct requesting person in your organization. We do not change your organization's registered fax # using info from this form
5. ***Member ID# --** Provide the correct member ID # for the primary Health Plan for the request submitted;
6. ***Member Name—**Provide member name;
7. ***DOB—**Provide member date of birth;
8. ***Ordering M.D.—**Provider who ordered or requested this service;
9. ***Primary Care Provider—**The member's primary care provider, even if the same as the ordering provider;
10. ***Dates of Service—**This should be the date(s) or date range for which the service will be performed;

12. ***Location of Procedure—**Indicates the facility where the procedure or service will be performed;
13. ***Identification of service area---** Check the box that best identifies what component of the providing facility applies;
14. ***Dx codes pertinent to this request—**The ICD-9 code must reflect the diagnosis(es) pertinent to this request and should be coded to the highest digit. Invalid ICD-9 codes will cause delays or potential denials;
15. ***Code Description—**Enter the ICD-9 description of code(s) listed in previous field(s);
16. ***CPT/HCPCS Codes—**List all codes applicable to the service you are requesting that require Prior Authorization;
17. ***Code Description—**List description of the CPT/HCPCS codes you have requested;
18. ****Quantity**--** Accurate identification of the quantity of service(s) being requested.

- Fax the form and the documentation to support your request to the FAX number provided at the top of the Prior Authorization Request Form.