



Prior Authorization Request: Inpatient or Outpatient

Individual • s name:	Date of birth:
Member ID number:	Individual • s phone number:
Ordering provider • s name and specialty:	Provider NPI:
Office address:	
Office phone number:	Office Email:
Rendering provider • s name and specialty:	Provider NPI:
Office address:	
Office phone number:	Office fax number:
Facility name:	Facility NPI:
Facility address:	
Date range of service / Total days requested:	
Service requested (include CPT code(s):	
Diagnosis code(s):	
Place of service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other _____	

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

 *Name and Title of Provider or Provider Representative Completing Form
 And Attestation (Please Print)

 *Date

***The attestation fields must be completed by a provider or provider representative in order for the request to be accepted.**