

Confidential

PRIOR AUTHORIZATION FORM
Fax to: 586.753.0981

Confidential

Requesting Provider Information:

Request Date: _____
Contact Name: _____
Phone #: _____
FAX #: _____
REQUESTING PROVIDER: _____
SPECIALTY: _____

- Elective
- Direct/Urgent
- Emergent

PATIENT NAME: _____ PATIENT DOB: _____

Subscriber Name: _____ Subscriber ID#: _____

Requested Service(s):

REQUESTED PROVIDER: _____

Phone #: _____ Fax #: _____

FACILITY (if applicable): _____ Inpatient Outpatient

DATE OF SERVICE(S): _____

DIAGNOSIS: 1 _____ ICD-9CODE: _____

2 _____ ICD-9 CODE: _____

PROCEDURE: 1 _____ CPT4 CODE: _____

PROCEDURE: 2 _____ CPT4 CODE: _____

OTHER: _____

Relevant Clinical Information: Please attach (if mailing) or fax all applicable clinical information.
(signs, symptoms, history, diagnostic test results, consultant recommendations (if applicable), plan of treatment)

Authorized Service(s): _____ CPT4 Code: _____

Other: _____

Comments/Instructions: _____

Authorization is limited to the services described above.

AUTHORIZATION #: _____ Expire Date: _____

(prior authorization approval is not a guarantee that a claim will be paid in full, as there may be other reasons to deny a claim)