Medical Prior Authorization Form

Fax Form To: 888 647-6152

Prior to completion, please review the list of specialty prior authorization forms available at *www.priorityhealth.com/provider/manual*

Reset Form

Date: _____ ☐ ***Provider Pre-service Organization Determination**

***Check only if requesting a pre-service determination for a Part C Medicare Advantage beneficiary.**

Member:

Last Name: _____ First Name:_____

Priority Health ID #:_____ Date of Birth: _____

Reason for Referral:

☐ **Non-participating Priority Health Provider** ☐ **Outpatient** ☐ **Transplant Related**

☐ **Elective Procedure** ☐ **Inpatient** ☐ **Inpatient thru Emergency Room**

Diagnosis: _____ Diagnosis code(s): _____

Treatment/testing: _____ Procedure code(s): _____

Date of visit/procedure:_____ Number of visits: _____

Requested By:

Provider name:_____ Phone:_____Fax: _____

Provider tax ID (required): _____ Specialty:_____

Address: _____ Contact name: _____

Directed To:

Provider name:_____ **Facility**: _____

Provider tax ID (required): _____ **Facility tax ID (required)**:_____

Address: _____ Address:_____

_____ _____

Provider phone: _____ Fax: _____ Facility phone:_____Fax:_____

Contact name: _____ Contact name: _____

For Inpatient Admissions:

Date of admission: _____ UR phone:_____UR fax:_____

Form completed by: _____ Phone:_____

Additional Information (i.e. what participating provider(s) has the member already seen if Out of Network request?):

_____

_____

_____

To facilitate prompt and accurate processing, the information above must be complete and all supporting clinical documentation related to this request MUST be submitted with this form.

Print

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