Pre-Authorization Request Form

Patient Information

Full Name

Date of Birth

Member/Insurance ID

Contact Number

Address

Provider Information

Provider Name

Phone

NPI Number

Facility Name

Facility Address

Requested Service/Procedure

Service/Procedure Description

CPT/HCPCS Code(s)

Diagnosis (ICD-10)

Proposed Start Date

Duration of Service

Medical Necessity/Justification

Additional Information

Notes

Provider Signature

_____

Date

_____

Patient/Guardian Signature

_____

Date

_____