Prior Authorization Request

Patient Information

Full Name	
Date of Birth	
Member ID / Policy #	
Phone Number	
Address	

Provider Information

Provider Name	
NPI / Tax ID	
Practice Name	
Phone Number	
Fax Number	
Address	

Requested Service / Medication

Requested Service/Medication	
Diagnosis/ICD-10 Code(s)	
Start Date	
Duration (if applicable)	
Dose/Frequency (if applicable)	

Clinical Rationale

Additional Notes / Attachments

Provider Signature

Date