Pre-Authorization Request Form

Patient Information

Full Name

Date of Birth

Member ID

Phone

Address

Requesting Provider

Provider Name

Provider NPI

Provider Phone

Provider Fax

Provider Address

Service Information

Service Description

CPT/HCPCS Code

Diagnosis (ICD-10)

Proposed Start Date

Proposed End Date

Quantity/Units

Medical Necessity/Clinical Rationale

Additional Information

Notes

Attestation

Name of Requestor

Signature

Date