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PHONE: 844-873-2905 FAX: 844-873-3163

PRIOR AUTHORIZATION REQUEST

*****Form must filled out completely and clinical information attached*****

Submitted by: (select one) ❑ PCP Office ❑ Specialist Office	Today's Date: / /
Person to contact for this Submission:	Phone:

Patient's Name:	**DOB:**	**Member ID**:

Requesting Provider Section: (i.e. Provider name not location or facility)		**Servicing Provider Section:** (i.e. Facility or Provider Name, May be the same as Requesting Provider)	
Requesting Provider Name:		Servicing Provider Name: Check here if same as Requesting ☐	
		Servicing Facility:	
NPI:		NPI:	
Tax ID:		Tax ID:	
Address:		Address:	
Fax:		Fax:	
Phone:		Phone:	
❑ Observation	❑ Inpatient	❑Outpatient	❑Ambulatory Surgery Center ❑Office

Check one and complete the date of service.

☐	Proposed Date of Service:	Proposed= Services that have not yet been provided.
☐	Retro Date of Service:	Retro= Services that have already been provided/started. Retro requests must be submitted within 30 days from the date of service.

ICD-10 Code	Diagnosis	ICD-10 Code	Diagnosis
1.		3.	
2.		4.	

CPT Code	Description	Units/Quantity
1.		
2.		
3.		
4.		
5.		

This request will be processed per the standard organization determination timeframes. If this request needs to be treated as "expedited", please note clinical justification why applying the standard timeframe for a determination could seriously **jeopardize the member's life, health or ability to regain maximum function:**

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to www.healthteamadvantage.com for specific codes requiring a prior authorization.