MEDICAL PRE-AUTHORIZATION AND NOTIFICATION FORM
Please print legibly or type. Please complete this form in its entirety. Missing information may create a longer processing time.

Name of Person Submitting Form:	
Phone Number:	
MEMBER (PATIENT) INFORMATION	
Name:	Date of Birth:
The Health Plan ID#:	PCP Name:
PROVIDER INFORMATION	
Requesting Physician/Provider	Servicing Provider/Facility/Physician
Name:	Name:
Address:	Address:
Phone Number:	Phone Number:
FAX Number:	
Provider Number:	
SERVICES REQUESTED	
DIAGNOSES (List of Codes & Descriptions)	
1.	2.
3.	4.
PROCEDURE/SERVICE (List all CPT/HCPCS Codes and Descriptions Required)	
1.	
2.	
3.	
4.	
Date(s) of Service:	# of Units/Visits:
If service is requested to a tertiary/out of plan network/non-network provider, explain why service cannot be provided in plan or in network:	
YOU MUST ATTACH ALL SUPPORTING CLINICAL INFORMATION (e.g. consultations, significant medical history, significant surgical history, lab reports, progress notes, clinical records/office notes) **PLEASE NOTE: DEPENDING ON THE INFORMATION YOU SUBMIT WE MAY REQUEST FURTHER PATIENT SPECIFIC INFORMATION TO PROCESS THIS REQUEST.**	