



Prior Authorization Request Form Medical Services and DME Supplies

Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.

<input type="checkbox"/>	Standard Review: (Attach supporting documentation).
<input type="checkbox"/>	Expedited Review: If standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. (Attach supporting documentation)

Please Note: Retroactive requests need to be submitted as a claim

Requestor Information

*Date: _____ Person completing form: _____ *Phone: _____
 *Provider/Clinic Name: _____ *Fax: _____

Member Information

*Name: _____ *ID#: _____ *DOB: _____

Requesting Provider Information

*Name: _____ MD FNP DO NP PA *Phone: _____

*Fax: _____ *NPI: _____

Appointment is scheduled for: _____

Delivering Provider / Facility Information

*Name: _____ ICD-10 Code(s): _____

*NPI: _____ Phone: _____

Procedure / Service / Item Information

CPT/HCPC & Modifier	Description	Quantity	Start Date	End Date
Surgery Information	<input type="checkbox"/> Outpatient Hospital or <input type="checkbox"/> ASC	Inpatient: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date: _____	Admit Date: _____	Discharge Date: _____	
Other important information: _____				

Fax completed forms with supporting documentation to 1-866-500-8773 for Douglas, Lyon, Storey, Washoe & Carson City Counties in Nevada

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.