BIOPHARMACY OUTPATIENT
Prior Authorization Fax Form

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

☐ Standard and Urgent Pre-Service Requests - Determination within 3 calendar days (72 hours) of receiving the request

INDICATES REQUIRED FIELD

MEMBER INFORMATION

Date of Birth *
☐☐☐☐☐☐☐☐
(MMDDYYYY)

Member ID *
☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name, First *
☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUESTING PROVIDER INFORMATION

Requesting NPI *
☐☐☐☐☐☐☐☐☐☐

Requesting TIN *
☐☐☐☐☐☐☐☐☐

Requesting Provider Contact Name
☐☐☐☐☐☐☐☐☐☐☐☐

Requesting Provider Name *
☐☐☐☐☐☐☐☐☐☐☐☐

Phone *
☐☐☐☐☐☐☐☐☐☐

Fax
☐☐☐☐☐☐☐☐☐☐

SERVICING PROVIDER / FACILITY INFORMATION

↳ ☐ *Same as Requesting Provider*

Servicing NPI *
☐☐☐☐☐☐☐☐☐☐

Servicing TIN *
☐☐☐☐☐☐☐☐☐

Servicing Provider Contact Name
☐☐☐☐☐☐☐☐☐☐☐☐

Servicing Provider/Facility Name *
☐☐☐☐☐☐☐☐☐☐☐☐

Phone *
☐☐☐☐☐☐☐☐☐☐

Fax
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AUTHORIZATION REQUEST

Primary Procedure Code *
☐☐☐☐☐ ☐☐
(CPT/HCPCS)   (Modifier)

Additional Procedure Code
☐☐☐☐☐ ☐☐
(CPT/HCPCS)   (Modifier)

Start Date OR Admission Date *
☐☐☐☐☐☐☐☐
(MMDDYYYY)

Diagnosis Code *
☐☐☐.☐☐☐
(ICD-10)

Additional Procedure Code
☐☐☐☐☐ ☐☐
(CPT/HCPCS)   (Modifier)

Additional Procedure Code
☐☐☐☐☐ ☐☐
(CPT/HCPCS)   (Modifier)

End Date OR Discharge Date *
☐☐☐☐☐☐☐☐
(MMDDYYYY)

Total Units/Visits/Days
☐☐☐☐

MEDICATION REQUESTED			
Medication Name	Strength	Dose	Quantity
Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)*			

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

SHP_20173960