Biopharmacy Outpatient

Prior Authorization Fax Form

Please fax this completed form to 833-913-2996 Date of request______________

☐ Request to modify existing authorization – please include auth number ____________________
Details on modification (i.e. units or dates to change)_______________________________

To the best of your knowledge, this request is a:

☐ New Request ☐ Continuation Request - approximate date initiated___________

☐ Expedited/Urgent Review Requested - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

____
Physician Signature

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID* ______________________ Date of Birth* ____________ Member Phone # ____________

Last Name* ______________________ First Name* ______________________

REQUESTING PROVIDER INFORMATION

Requesting NPI* ____________ Requesting TIN* ____________ Requesting Provider Contact Name ______________________

Requesting Provider Name* ____________ Specialty ____________ Phone* ____________ Fax* ____________

SERVICING PROVIDER/FACILITY INFORMATION ☐Same as requesting provider

Servicing NPI* ____________ Servicing TIN* ____________ Servicing Provider Contact Name ______________________

Servicing Provider Name* ____________ Specialty ____________ Phone* ____________ Fax* ____________

AUTHORIZATION REQUEST

Primary Procedure Code* ____________ (CPT/HCPSS) ______ (Modifier)
Additional Procedure Code ____________ (CPT/HCPSS) ______ (Modifier)
Start Date ________ MMDDYYY
Diagnosis Code ________ ICD10

Additional Procedure Code ____________ (CPT/HCPSS) ______ (Modifier)
Additional Procedure Code ____________ (CPT/HCPSS) ______ (Modifier)
End Date ________ MMDDYYY

MEDICATION REQUESTED

Medication Name* ____________ Dose Per Visit* ____________ Frequency* ____________ Total Number of Visits* ____________

Rationale for request and pertinent clinical information is required for all prior authorizations and should be attached to this request. Lack of clinical information may result in delayed determination

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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