PRIOR AUTHORIZATION REQUEST

Community ProHealth Medical Management

Telephone 317.621.7575/800.344.8672 Fax: 317.621.7984/844.782.9380

Patient Name: _____ DOB: _____

ID#: _____ Insurance Plan: _____

PCP Name: _____ PCP Phone #_____ PCP Fax #_____

Diagnosis: _____ ICD-10 Code(s): _____

Procedure: _____ CPT-4 Code(s): _____

Vendor/Facility: _____ Requested Service_____

Date of requested service_____ Days/ Visits Requested_____

Referred by: _____ Phone #_____ Fax# _____

Person submitting request: _____ Phone#: _____ Fax #: _____

SPECIALTY REFERRAL

Specialist Name (MD Name): _____ Specialty: _____

Requested Service_____ Service Type/ Vendor _____

Date(s) of Service/ Procedure: _____

Consult Only: ☐ Consult & Treat: ☐ OON ☐ Documentation Attached☐

Additional Medical Information: _____

_____

Resubmission Date: _____ Date Request Received _____

Referral Type: Self Referred: _____ Referred by PCP: _____ OON_____

If requesting approval for non-participating provider, indicate why participating provider cannot provide service. If request is not completed in full, request will be returned.

PLEASE DO NOT WRITE BELOW THIS LINE FOR PROHEALTH USE ONLY

Authorization #: _____ # of Visits/ Days/Months Approved: _____

Time Frame: __/__/__ to __/__/__

___Urgent ___Pre-Service ____ Concurrent ___Non-Urgent ____ Post Service ____Retrospective

Authorizing Agent: _____ Phone #: _____ Date Submitted: _____

Reviewed/Updated 4/2016