PRIOR AUTHORIZATION REFERRAL FORM

PHONE: 800-482-0945 FAX: 248-583-4647

Fax completed form to: Attention PA Department

PATIENT

Patient Name: ________________________

Date of Birth: ________________________

Relationship to Employee:______________

Patient Since:_________________________

EMPLOYEE ID:

Member Name:_____________________________

Member ID:_______________________________

Group Number:____________________________

REQUESTING PROVIDER

Name:________________________________

NPI:_________________________________

Tax ID:______________________________

Phone:_______________________________

Fax:_________________________________

REFEFFERING PROVIDER

Name:________________________________

NPI:_________________________________

Tax ID:______________________________

Phone:_______________________________

Fax:_________________________________

PRIOR-AUTHORIZATION REQUEST

Date of Procedure or Service:_________________________ Urgent Request ☐

Principal ICD-10 Diagnosis Code(s):____

Principal Procedure/Service Description:____

CPT Codes: ____

Other:____

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- ✓ Fax related medical records and diagnostic test results to support Medical Necessity of proposed procedure/service.

Name of Submitter:_________________________ Phone Number:_________________________

Submitter’s Email:_________________________ Fax:__________________________________