QCP PRIOR AUTHORIZATION REFERRAL FORM

FAX: (740) 455-8817

Fax completed form to: **QUALITY CARE PARTNERS** - 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: _____
Address: _____
City: _____ State__ Zip_____

REFERRING PROVIDER

Name: _____
NPI: _____
Tax ID: _____
Phone: _____
Fax: _____
Address: _____
City: _____ State__Zip_____

PRIOR-AUTHORIZATION REQUEST: Urgent Request ☐ Post-Service Request ☐

Date of Procedure or Service: _____
Primary ICD-10 Diagnosis Code(s): _____
Primary Procedure/Service Description: _____
CPT Codes: _____
Other: _____
_____

Place of Service: Inpatient ☐ Outpatient ☐ Facility Name & Address: _____
_____

- 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: _____

For assistance submitting your request, please contact Mid-America Associates, Inc. at 800-482-0945.