MID AMERICA
EMPLOYEE BENEFIT ADMINISTRATION

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 at 800-482-0945.