



Urgent Review

Standard Review

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MEDICAL PRIOR AUTHORIZATION REQUEST FORM - PLEASE FAX FORM TO: 740 522-5002

MEMBER/PATIENT INFORMATION (REQUIRED)					
Name:			ID #:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			Date of Birth:		
City:	State:	Zip code:	Phone:		
PROVIDER INFORMATION (REQUIRED)					
Provider Name:		NPI#:	Specialty:		
Address:			Office contact name:		
City:	State:	Zip code:	Office Phone:	Office Fax:	
TREATMENT INFORMATION (REQUIRED)					
Type of Treatment:			Diagnosis:		
Frequency:			Duration:		
Has the Patient been compliant with previous treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes					
CLINICAL INFORMATION (REQUIRED)					
What treatment(s) has the patient tried and failed?					
Additional Comments:					
*Please provide any office notes, diagnostic testing results and other medical information that supports the need for this service.					

Provider Signature: _____ Date: _____

By signature, the Provider (or agent of the provider) confirms that all information provided is accurate.