❑ **Urgent Review** ❑ **Standard Review**

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(800) 686-8425 Fax: 740 522-5002
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MEDICAL PRIOR AUTHORIZATION REQUEST FORM - PLEASE FAX FORM TO: 740 522-5002

MEMBER/PATIENT INFORMATION (REQUIRED)				
Name:			ID #:	Sex: ❑ Male ❑ 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:	
CPT/HCPC code(s):			ICD-10 code(s):	
Frequency:			Duration:	
Has the Patient been compliant with previous treatment? ❑ No ❑ 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.