

Prior Authorization and Insurance Referral Form

Instructions: Please complete all sections legibly. This document is formatted for printing and manual submission.

1. Insurance Plan Information

Insurance Company Name:

Prior Authorization Department Fax Number:

Prior Authorization Department Phone Number:

2. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Gender:

Insurance Member ID Number:

Insurance Group Number:

Patient Phone Number:

3. Requesting Provider Information

Requesting Provider Name:

National Provider Identifier (NPI):

Tax Identification Number (TIN):

Clinic/Facility Address:

Contact Person Name:

Phone Number:

Fax Number:

4. Servicing Provider / Facility Information (Where Referral is Sent)

Servicing Provider / Facility Name:

National Provider Identifier (NPI):

Address where service will be performed:

Phone Number:

Fax Number:

5. Clinical Information and Referral Details

Diagnosis Code (ICD-10 Code):

Diagnosis Description:

Requested Procedure / Service (CPT / HCPCS Code):

Procedure Description:

Number of Visits or Units Requested:

Requested Start Date of Service (MM/DD/YYYY):

Requested End Date of Service (MM/DD/YYYY):

Clinical Reason / Medical Necessity Summary:

6. Authorization / Referral Decision (For Insurance Use Only)

Authorization Status:

Authorization Reference Number:

Approved Quantity / Units:

Approved Date Range (From - To):

Reviewer Name and Signature:

Decision Date (MM/DD/YYYY):