Request for Prior Authorization

COMPLETE THIS FORM AND FAX WITH MEDICAL RECORDS TO: (559) 224-2693

Please check one of the following:

☐ Standard Request ☐ Expedited Request

<table>
<tr><td colspan="3">MEMBER NAME:</td><td colspan="2">DOB:</td></tr>
<tr><td colspan="3">INSURANCE ID NUMBER:</td><td colspan="2">GENDER: ☐ MALE ☐ FEMALE</td></tr>
<tr><td colspan="3">ORDERING PROVIDER:</td><td colspan="2">PROVIDER ID:</td></tr>
<tr><td colspan="2">CONTACT PERSON:</td><td colspan="2">TELEPHONE:</td><td>FAX:</td></tr>
<tr><td>NAME OF PCP:</td><td colspan="3">SIGNATURE OF ORDERING PROVIDER:</td><td>DATE:</td></tr>
<tr><td colspan="3">FACILITY OR PROVIDER REQUESTED:</td><td colspan="2">TAX ID:</td></tr>
<tr><td colspan="2">ADDRESS:</td><td colspan="2">TELEPHONE:</td><td>FAX:</td></tr>
<tr><td colspan="2">☐ NEW PATIENT REFERRAL</td><td colspan="3">☐ CONTINUITY OF CARE PATIENT SINCE:</td></tr>
<tr><td colspan="2">DATE / DATE RANGE OF SERVICE:</td><td colspan="3">TYPE OF SERVICE: ☐ OUTPATIENT ☐ INPATIENT
☐ RADIOLOGY ☐ 2ND OPINION CONSULT
☐ OTHER: ____________</td></tr>
<tr><td colspan="2">DIAGNOSIS CODES:</td><td colspan="3">DESCRIPTION:</td></tr>
<tr><td colspan="2">CPT CODES:</td><td colspan="3">SERVICE REQUESTED:</td></tr>
</table>

***PLEASE SUBMIT APPROPRIATE SUPPORTING CLINICAL INFORMATION WITH THIS FORM**

Within 5 days before the actual date of service, provider MUST confirm that the member's health plan coverage is still in effect. With the exception of urgent requests, it is recommended that you do not schedule appointments prior to authorization approval. Emergency services do not require prior authorization and are reviewed retrospectively for necessity.

FOR QUESTIONS OR TO VERIFY BENEFITS PLEASE CALL: (855) 343-2247

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