

Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**



Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 888 647-6152

General

Specialty forms exist for: ACDs (Medicaid Only), Bariatric Surgery, Bariatric Surgery Evaluation, Breast and Ovarian Cancer Screening, Carotid Artery Stenting, Continuous Glucose Monitoring Systems, Enteral Nutrition Therapy, Gene Expression Analysis: Breast Cancer Treatment Assessment with Oncotype DX™, ICD & Biventricular Pacemakers, IVIG, Medical Weight Loss, Obstetrical, Oxygen Therapy and Apnea Monitors Notification Form (Medicaid Only), Reduction Mammoplasty (Bilateral), Referral to Non-Participating Provider and Spine Referral for Neurosurgeon or Orthopedic Surgeon Evaluation

Please complete and fax along with any additional pertinent medical documentation

Member:

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Plan/Product Type: EPO HMO POS SF-POS PPO Medicaid Medicare

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Has PCP been notified of request? Yes No Is this authorization related to: Work Injury Motor Vehicle Accident

Requested By:

Provider Name: _____ Phone: _____ Fax: _____

Address: _____ Contact Name: _____

_____ Date of Request: _____

Directed To:

Provider Name: _____ Facility: _____

Address: _____ Address: _____

Provider Phone: _____ Fax: _____ Facility Phone: _____ Fax: _____

Contact Name: _____ Contact Name: _____

Reason:

Inpatient Admission Plastic/Reconstructive Surgery Non-Priority Health Provider (refer to Priority Health Directory / *FIND A DOCTOR*)

Oral/Orthognathic Surgery UPPP* Neuropsychologic Eval. (non-par requests only)

Other – List Below _____
(*prior auth only required for:
EPO, PPO, Medicaid, MICHild,
POS (self-funded)

Diagnosis _____ Procedure _____
Diagnosis Code(s), if known _____ Procedure Code(s) _____
_____ Date of Procedure _____
_____ Number of Visits _____

For Inpatient Admissions please ✓ the following which apply:

- Needs assistance or assistive devices for mobility Needs assistance with activities of daily living
 Lives alone or without household support Has medical comorbidities that could prolong hospitalization
 Has chronic pain

*****ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW*****

Approved Denied

Authorization # _____

Last Revision: December 2009