

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

Referral to Non-Participating Provider / Out of Network Services

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: _____

If requesting Provider is not the PCP, what is the Provider's Specialty? _____

Address: _____ Contact Name: _____

_____ Date of Request: _____

Directed To: (Please complete Provider and Facility information when applicable - Ex. Dr. Smith – U of PH)

Provider Name: _____ Facility: _____

Address: _____ Address: _____

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

Contact Name: _____ Contact Name: _____

Date of Service/Admission: _____ Estimated length of stay for admission, if applicable: _____

Office Consult Only Office Consult/Testing/Treatment Procedure

Procedure Code(s): _____ Treatment/Testing: _____

Diagnosis: _____ Diagnosis Code(s): _____

All of the following questions must be answered. The Medical Director's decision will be based on information submitted.

1. What participating provider(s) has member consulted with regarding this medical problem? Include name(s) of provider(s) and date(s) of service and any diagnostic testing and results. **Include most recent PCP and specialist notes related to request.**

2. Is care available within the Priority Health Network? Yes or No (If unsure, please refer to Priority Health Directory / *FIND A DOCTOR*)

3. Why is member being referred to a non-participating provider?

NOTE: If request is for **future visit**, all notes from visits thus far that are related to this diagnosis **MUST** be included, including visits with participating and non-participating providers and/or facilities.

If request is for **past visit**, all notes from requested date(s) of service must be included.

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