

Medical Prior Authorization Form

Fax Form To: 888 647-6152



Prior to completion, please review list of specialty prior authorization forms available below and complete specialty form, if applicable.

The following Specialty forms can be found at *priorityhealth.com* in the Provider Center: Durable Medical Equipment (DME), ACDs (Medicaid Only), Bariatric Surgery, Bariatric Surgery Evaluation, Breast and Ovarian Cancer Screening by Molecular Testing, Enteral Nutrition Therapy, Genetic Testing, Home Health Care, ICD & Biventricular Pacemakers, IVIG, Medical Weight Loss, Obstetrical, Oxygen Therapy and Apnea Monitors Notification Form (Medicaid Only), Reduction Mammoplasty (Bilateral), and Spine Referral for Neurosurgeon or Orthopedic Surgeon Evaluation.

Date: _____

Member:

Last Name: _____ First Name: _____

Priority Health ID #: _____ Date of Birth: _____

Reason for Referral:

- Non-participating Priority Health Provider Outpatient Transplant Related
 Elective Procedure Inpatient Inpatient thru Emergency Room

Diagnosis: _____ Diagnosis Code(s): _____

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

Date of Visit/Procedure: _____ Number of Visits: _____

Requested By:

Provider Name: _____ Phone: _____ Fax: _____

Provider Tax ID: _____ Specialty: _____

Address: _____ Contact Name: _____

Directed To:

Provider Name: _____ Facility: _____

Provider Tax ID: _____ Facility Tax ID: _____

Address: _____ Address: _____

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

Contact Name: _____ Contact Name: _____

Additional Information (i.e. what participating provider(s) has the member already seen if Out of Network request?):

To facilitate prompt and accurate processing, the information above must be complete and all supporting clinical documentation related to this request MUST be submitted with this form.