

## Prior Authorization Request Form

Phone (832) 828-1004 Fax: (832) 825-8760

Pre-certification is a condition of reimbursement. It is not a guarantee of payment. It is the responsibility of each provider to verify the member's eligibility prior to rendering services. Providers should initiate the prior authorization process 3-5 business days prior to a scheduled service. A response will be given within 72 hours. **An incomplete pre-certification request form will delay processing of your request.**

Date: \_\_\_\_\_ Name of person completing form: \_\_\_\_\_

Office number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Member name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M or F

Member ID number: \_\_\_\_\_

Primary care provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Requesting provider name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Pay to affiliate: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Facility: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 Code(s): \_\_\_\_\_

Service(s)/procedures(s) you are requesting: \_\_\_\_\_

Date of service: \_\_\_\_\_ Estimated LOS required: \_\_\_\_\_  
(Number of days requesting)

Medical history (Please attach all documentation relevant to the requested procedure) Required for review.

HCPCS/CPT 4 code(s):	Visits/units:	Medicaid type of service code:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____

**Place of service**

Inpatient       Observation

Outpatient       Home

Physician's Office       Day Surgery

Other insurance: \_\_\_\_\_ Other insurance phone number: \_\_\_\_\_

**(PLEASE DO NOT WRITE BELOW THIS LINE.)**

Approved     Denied

Effective date: \_\_\_\_\_

Authorization number: \_\_\_\_\_

Expiration date: \_\_\_\_\_