



Phone / 1-800-390-7102 • Fax / 1-888-577-5507 • Retrospective Fax / 1-888-527-0016

PRIOR AUTHORIZATION REQUEST FORM

Routine Urgent (72 hours)

PATIENT INFORMATION

Date of Request _____ Medicaid ID # _____
Patient's Last Name _____ First Name _____
DOB _____ Phone Number _____

ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT OF PROBLEM. INCOMPLETE INFORMATION DELAYS DECISION PROCESS.

PROVIDER INFORMATION

Requesting Provider: Name _____ Phone _____ Fax _____
Requesting Provider's Address of Service _____
Date of Service(s) Requested _____
Facility / Service Provider (First & Last Name) _____
Specialty _____
Service Provider's Address of Service _____
Phone _____ Fax _____
Service Provider Tax ID _____ NPI _____ DX Codes (ICD-9) _____
DX Description _____
History _____

Procedures/Services/Surgery _____
Procedure Codes (CPT) _____
 Inpatient Outpatient

SPECIALIST CONSULTATIONS:

1 2 3 4 5 6 Other _____ visit(s); Refer back to PCP with report
 Update Authorization Number: _____ # of Visits _____ Requested Extension Date: _____

OTHER LIABILITY:

Work/Auto/Other Insurance _____

This Form Completed by: _____

THIS SECTION CARESOURCE USE ONLY

AUTHORIZATION INFORMATION

Authorization: Approved Denied Pended Duplicate Request
Authorization Number: _____ # of visits/treatments _____
Authorization To: _____ From: _____
Comments: _____
CareSource Staff Signature _____ Date _____

All non participating providers must obtain authorization prior to services being rendered. Refer to the CareSource Prior Authorization list. Member eligibility must be determined on date of service. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.