



Ohio Provider Medical Prior Authorization Request Form

Routine Urgent (72 hours)

PATIENT INFORMATION

Date of Request _____ Member ID # _____
Member's Last Name _____ First Name _____
Member Address _____
DOB _____ Phone Number _____

ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

Inpatient Outpatient

Ordering Provider Name _____
Tax ID _____ NPI _____
Phone _____ Fax _____
Ordering Provider Address _____
Date of Service(s) Requested _____
Facility / Service Provider (First and Last Name) _____
Provider Address _____
Phone _____ Fax _____
Tax ID _____ NPI _____ DX Codes (ICD-9) _____
DX Description _____
Additional Information _____
Requested Procedures / Services / Surgery _____
Procedure Codes (CPT/HCPCS) _____

Qty.	HCPCS Code	Durable Medical Equipment/Orthotics/Prosthetics/Vision, Make & Model, etc.	U&C Charge

NUMBER OF VISITS

(Circle) 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 (Date) _____
CareSource Staff Signature _____ Date _____

All non-par providers must have an authorization PRIOR to services rendered. Approved Prior Authorizations payment is contingent upon the eligibility of the member at the time of service, services billed must be within the provider's scope of practice as determined by the applicable fee/payment schedule and the claim timely filing limits. Authorizations are not a guarantee of payment, but are based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and/or qualifications and will be determined when the claim is received for processing.