



Phone: 1-800-488-0134

Fax: 1-888-752-0012

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

PROVIDER INFORMATION

Requesting Provider Name _____
Phone _____ Fax _____
Requesting 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) _____
 Inpatient Outpatient

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 _____
Comments _____
CareSource Staff Signature _____ Date _____

The non-par SPECIALIST must have an authorization PRIOR to services rendered. Refer to CareSource "Prior Authorization" and "No Prior Authorization" lists. Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. 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.