**Phone:** 1-800-488-0134
**Fax:** 1-888-417-6157

# CareSource® MyCare Ohio (HMO D-SNP)
# Provider Prior Authorization Request Form

* indicates required field

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Routine* | | Urgent* | | | |

## Patient Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Request | | Member ID Number* | | | | | |
| Member's Last Name* | | First Name* | | | | | |
| Date of Birth* | | Phone Number | | | | | |
| Member Address | | City | | State | | Zip Code | |

**ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Inpatient* | | Outpatient* | | | | | |
| **Place of Service** | | | | | | | | | |
| ☐ Office | ☐ Home | ☐ Inpatient Hospital | ☐ Outpatient Hospital | ☐ Other | | | | | |
| Ordering Provider Name (First & Last Name)* | | | | | | | | | |
| Ord-Tax ID* | | Ord-NPI* | | Ord-Phone* | | | | | |
| Ord-Address* | | Ord-City* | | Ord-State* | | Ord-Zip Code* | | | |
| Ord-Fax* | | | | | | | | | |
| Date of Service Start Date (mm/dd/yyyy) | | Date of Service End Date (mm/dd/yyyy) | | | | | | | |
| Facility/Servicing Provider Name (First & Last Name)* | | | | | | | | | |
| Svc-Tax ID* | | Svc-NPI* | | | | | | | |
| Svc-Address* | | | | | | | | | |
| Svc-City* | | Svc-State* | | Svc-ZIP* | | Fac-Phone* | | | |
| Svc-Fax* | | | | | | | | | |
| DX Code (1) | | DX Code (2) | | DX Code (3) | | | | | |
| Additional Information | | | | | | | | | |

**CPT/HCPCS**

| Qty* | CPT/HCPCS* | Description of Service | U&C Charge |
|---|---|---|---|
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|---|---|---|---|---|---|
| Number of Visits | | | | | |
| Update Authorization Number | | # of visits | | Requested Extension Date | |
| | | | | | |
| Work/Auto/Other Insurance | | | | | |
| Contact Name (First & Last)* | | | | | |
| Contact Phone #* | | | Contact Fax #* | | |

All non-par providers must have an authorization **prior** to services rendered. Approved prior authorization 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.