



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

* indicates required field

	<input type="checkbox"/> Routine*	<input type="checkbox"/> 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

	<input type="checkbox"/> Inpatient*	<input type="checkbox"/> Outpatient*	
Place of Service			
<input type="checkbox"/> Office	<input type="checkbox"/> Home	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> 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

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.