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## Ohio MyCare/Medicare Advantage Provider Medical Prior Authorization Request Form

☐ Routine ☐ Urgent

### PATIENT INFORMATION

Date of Request \_\_\_\_\_ Member ID # \_\_\_\_\_ Plan Name \_\_\_\_\_  
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 \_\_\_\_\_  
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); PCP Referral Y/N

☐ Existing Authorization Number \_\_\_\_\_

### OTHER LIABILITY

☐ Work / Auto / Other Insurance \_\_\_\_\_

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.