Phone: 1-833-230-2101
Fax: 1-844-676-0372
Sick Newborn Fax: 937-396-3499

HAP CareSource (Marketplace Plan)
Provider Prior Authorization Request Form

***Indicates required field**

Routine* ☐ Urgent* ☐

Patient Information

Date of Request		Member ID Number*					
Member's Last Name*		Member's First Name*					
Date of Birth*		Phone Number					
Member Address		City		State		ZIP	

ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

Inpatient* ☐ Outpatient* ☐

Place of Service

☐ Office ☐ Home ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Other:

Ordering (Ord) Provider Name (First & Last)*		Ord-Phone*	
Ord-Tax ID*	Ord-NPI*	Ord-Fax*	
Ord-Address*	Ord-City*	Ord-State*	Ord-ZIP*
Date of Service, Start Date (mm/dd/yyyy)		Date of Service, End Date	
Servicing (Svc) Provider Name (First & Last)*		Svc-Phone*	
Svc-Tax ID*	Svc-NPI*	Svc-Fax*	
Svc-Address*	Svc-City*	Svc-State*	Svc-ZIP*
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	
Requested Extension Date	

Work/Auto/Other Insurance			
Contact Name (First & Last)*			
Contact Phone Number*		Contact Fax Number*	

All non-participating 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.