

Marketplace Provider Prior Authorization Request Form

* indicates required field

		<input type="checkbox"/> Routine*	<input type="checkbox"/> Urgent*
Patient Information			
Date of Request		Member ID #*	
Member's Last Name*		Member's First Name*	
Member's Date of Birth*		Phone Number	
Member's Address		City	State ZIP

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
Ordering (Ord) Provider Name (First & Last Name)*			
Ord-Tax ID*		Ord-NPI*	Ord-Phone*
Ord-Fax*			
Ord-Address*		Ord-City*	Ord-State* Ord-ZIP*
Date of Service Start Date (mm/dd/yyyy)		Date of Service End Date (mm/dd/yyyy)	
Facility/Servicing (Svc) Provider Name (First & Last Name)*			
Svc-Tax ID*		Svc-NPI*	
Svc-Address*			
Svc-City*		Svc-State*	Svc-ZIP* Svc-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		
Updated Authorization Number	Number of visits	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.