CareSource

Phone: 1-**800-679-7865**
Fax: 844-676-0370

Ohio MyCare Provider Prior Authorization Request Form

* Indicates Required Field

☐ Routine* ☐ 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

☐ 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*	
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*		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		# 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.