CareSource

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Ohio MyCare 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.