CareSource

Phone / 1-800-390-7102 • Fax / 1-888-577-5507

PRIOR AUTHORIZATION REQUEST FORM

❒ **Routine** ❒ **Urgent (72 hours)**

PATIENT INFORMATION

Date of Request _____ Medicaid ID # _____

Patient's Last Name _____ First Name _____

DOB _____ Phone Number _____

ATTACH CLINICAL NOTES TO SUPPORT MEDICAL NECESSITY WITH HISTORY AND TREATMENT OF PROBLEM. INCOMPLETE INFORMATION DELAYS DECISION PROCESS.

PROVIDER INFORMATION

Requesting Provider: Name _____ Phone _____ Fax _____

Location / Address of Service _____

Date of Service(s) Requested _____

Facility / Service Provider (First & Last Name) _____

Location / Address of Service _____

Phone _____ Fax _____

Tax ID _____ NPI _____ **DX Codes (ICD-9)** _____

DX Description _____

History _____

_____

Procedures/Services/Surgery _____

Procedure Codes (CPT) _____

❒ **Inpatient** ❒ **Outpatient**

SPECIALIST CONSULTATIONS:

❒ 1 2 3 4 5 6 Other _____ visit(s); Refer back to PCP with report

❒ Update Authorization Number: _____ # of Visits ____ Requested Extension Date: _____

OTHER LIABILITY:

❒ Work/Auto/Other Insurance _____

This Form Completed by:_____

THIS SECTION CARESOURCE USE ONLY

AUTHORIZATION INFORMATION

Authorization: ❒ Approved ❒ Denied ❒ Pended ❒ Duplicate Request

Authorization Number: _____ # of visits/treatments _____

Authorization To: _____ From: _____

Comments: _____

CareSource Staff Signature _____ Date _____

The non-par SPECIALIST must have an authorization PRIOR to services being rendered. Refer to CareSource "Prior Authorization" and "No Prior Authorization" lists. Failure to do so may result in a denial and NON-PAYMENT for services. Retro-authorizations are NOT honored. Member eligibility must be determined on date of service.