

Ohio Medicare Provider Prior Authorization Request Form

* indicates required field

Routine*		Urgent*	
Patient Information			
Date of Request		Member ID #*	
Member's Last Name*		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
Ordering Provider Name (First & Last Name)*			
Ord-Tax ID*		Ord-NPI*	Ord-Phone*
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 Provider Name (First & Last Name)*			
Svc-Tax ID*		Svc-NPI*	
Svc-Address*			
Svc-City*	Svc-State*	Svc-ZIP*	Fac-Phone*
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	# 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.