



PRIOR AUTHORIZATION FORM

* For URGENT requests please contact MCP by phone*

Today's Date:

MCP Name:

1.	Member ID	DOB	
	Last Name	First Name	
	Member Phone Number ()		
2.	Is there another Insurance Carrier for this service?		
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	If yes, name of company		Policy Number:
3.	Referral Service Type Requested		
	Please refer to the Plan's Prior Authorization List for those services that require prior authorization		
	Ambulatory Surgery	<input type="checkbox"/>	Out of Network Provider <input type="checkbox"/>
	Cosmetic/Plastic Procedure	<input type="checkbox"/>	Diagnostic Testing <input type="checkbox"/>
	Elective/Scheduled Admission	<input type="checkbox"/>	Office Procedure <input type="checkbox"/>
	DME/Home Infusion	<input type="checkbox"/>	OB Services <input type="checkbox"/>
	Pain Management	<input type="checkbox"/>	Specialty Referral <input type="checkbox"/>
	Outpatient PT/OT/ST	<input type="checkbox"/>	Other <input type="checkbox"/>
4.	Requesting Provider Information		
	Provider ID Number:		
	Provider NPI:		
	Requesting Provider Name: (Last, First)		
	Specialty:		
	Phone Number:		
	Fax number:		
	Requesting Provider Address:		
5.	Referred to Provider/Facility Information		
	Type: Office <input type="checkbox"/> OP Hospital <input type="checkbox"/> IP Hospital <input type="checkbox"/> Free Standing Facility <input type="checkbox"/>		
	Provider/Facility ID Number:		
	Provider NPI:		
	Provider/Facility Name:		
	Specialty:		
	Phone Number:		
	Fax Number:		
	Provider/Facility Address:		
6.	Service Requested		
	Planned Date of Service	EDC	(OB Notification)
	Primary ICD-9 Code		Description
	CPT Code(s) or HCPC Code(s)		Description
	Visits/Frequency/Duration		
	Clinical Indications for the Request: (May attach clinical or progress notes. Please include pertinent previous testing results):		
7.	<u>PLAN ADMINISTRATIVE USE ONLY:</u>		
	Service request status:		
	Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied <input type="checkbox"/>		
	Comments:		