PREAUTHORIZATION REQUEST FORM

Fax Number: (787) 332-0921 / Phone Number: (855) 297-0140

Beneficiary Information
Beneficiary Name:
ID Number:
DOB:
Beneficiary Phone #:

Type of request:
☐ Standard Request / Routine
☐ Expedited / Urgent Request (When waiting for a decision under a Standard timeframe -72 hrs-could place the life, health, safety, or ability to regain maximum function of the beneficiary in serious jeopardy)

****IN ORDER TO PROCESS YOUR REQUEST, THIS FORM MUST BE COMPLETE AND LEGIBLE****

NOTE: This request must be accompanied by a physician's order and all other pertinent clinical documentation for appropriate evaluation. Additional documentation may include, but is not limited to:

- Physicians' Orders
- Progress Notes
- Clinical Summary
- Diagnostic Test Results
- Prior Treatments
- Discharge Information

Requesting Provider		
Provider Name:	NPI:	Contact Person:
Phone #:	Fax #:	

Rendering Provider / Facility		
Provider Name:	NPI:	Provider's Specialty:
Phone #:	Fax #:	

Authorization Request

Outpatient		Inpatient
☐ Surgical Procedure	☐ Home Health	☐ Surgical Procedure
☐ Imaging	○ Skilled Services (SN, PT, OT, ST)	☐ Other Procedure / Tx
☐ Specialty Lab	○ IV Infusion	
☐ PT, OT, ST	○ Wound Care	
☐ Cardiovascular Procedure	☐ Discharge Planning	
☐ DME	☐ Other: _____	
☐ Prosthetics		

Diagnosis Code & Description	
Code	**Description**

Procedure / Service Code & Description			
Code	**Description**	**Quantity**	**DOS**

Additional Relevant Information: