



PARTNERS
HEALTH PLAN

PHP CARE COMPLETE FIDA-IDD PLAN's Prior Authorization Request Form

Participant Name: _____ Participant ID #: 450000_____ (fill in last 7 digits)
 Sex: _____ DOB: _____ Phone Number: (____) _____
 Address: _____
 County of Residence: _____

Participant Representative: _____ Phone Number: (____) _____
 Address: _____
 Participant PHP Care Manager: _____ Phone: (____) _____

Requesting Provider Name: _____ NPI: _____
 Address: _____
 Phone Number: (____) _____ Extension: _____

Servicing Providing Name (if different) : _____ NPI: _____
 Address: _____
 Phone Number: (____) _____ Extension: _____

Contact Name (person completing form): _____
 Phone Number: (____) _____ Extension: _____

Check One: Inpatient Outpatient

Retrospective Request: Yes If Yes, Date Service Provided: _____
 Reason for failure to prior authorize: _____

Procedure or DME Being Requested: _____ CPT: _____

Pertinent Diagnosis: _____
 Pertinent Diagnosis Code (s): _____

Description of Symptoms:

Prior Treatment Provided (i.e., PT, NSAIDS):

Related Labs/Diagnostic Studies Results (i.e., X-Rays, Ultrasound, Labs):

Please fax completed form, along with clinical information, to: 855-769-2509
For questions, please call 855-769-2508