PHP CARE PREFERRED - Prior Authorization Request Form

Participant Name: ________________________Participant ID #: ___________________________
Sex: _____ DOB: ___________ Phone Number: (___) _______________
Address: ____
County of Residence: ___________________

Participant Representative: _________________________ Phone Number: (___) ____________
Address: ____

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