

Plan name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: [] - [] - [] Fax: [] - [] - []
Email: _____

Is this request urgent? Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. –Or– In the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment. If this request is urgent and meets the definition as indicated above, please check this box.

Urgent request

Instructions: This pre-authorization request form should be filled out by the provider. Before completing this form, please confirm the patient’s benefits and eligibility. Benefits for services received are subject to eligibility and plan terms and conditions that are in place at the time services are provided.

Uniform Prior Authorization Prescription Request Form

Date: [] / [] / []

Verify with the preauthorization list on the “[One Health Port](#)”, according to the company’s procedure, or call the number on the back of the member’s card.

Is this request: New Authorization extension Providing additional information

If you already have an authorization number, list it here: _____

1. Patient information

Name Last: _____ First: _____ MI: _____

Member ID #: _____ and Group number: _____

Secondary insurer member ID #: _____ and Group number: _____

Height: _____ Weight: _____ Male Female DOB: [] / [] / []

Allergies: _____

2. Prescriber / Provider information

Check one: You are the Requesting provider Servicing provider Specialty: _____

Provider name: _____ Tax ID number: _____

Phone: [] - [] - [] Fax: [] - [] - []

NPI: _____ DEA number (if required): _____

Provider address: _____

Who should we contact if we require more information? Name: _____

Phone: [] - [] - [] Fax: [] - [] - []

3. Patient's PCP information (if applicable)

Name: _____
Phone: - - ext. Fax: - -

4. Medication / Medical and Dispensing Information

Medication name: _____
Dose/strength: _____ Frequency: _____ Length of therapy/#refills: _____ / _____ Quantity: _____
 New therapy Renewal If Renewal: date therapy initiated / /
Route of administration: Oral/SL Topical Injection IV Other: _____
Administered: Doctor's office Dialysis center Home health By patient Other: _____

List of previous drugs tried

Drug name:	Dosage:
_____	_____
_____	_____
_____	_____

Provide the medical rationale for requested drug (include chart notes and supporting labs) and why a formulary alternative is not acceptable:

Provide all ICD-9 or ICD-10 codes and their descriptions, if available; this will help us process your request.

Diagnosis: _____
Codes and descriptions are: ICD-9 ICD-10
Primary: _____
Second: _____
Third: _____

Submit the following clinical information with this form as appropriate for this request: History & Physical • Lab/radiology/testing results • Current symptoms and functional impairments • Treatment history • *Any other information such as chart notes that support medical necessity for the request.*