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?** ☐ **YES** ☐ **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	☐	Out of Network Provider	☐
	Cosmetic/Plastic Procedure	☐	Diagnostic Testing	☐
	Elective/Scheduled Admission	☐	Office Procedure	☐
	DME/Home Infusion	☐	OB Services	☐
	Pain Management	☐	Specialty Referral	☐
	Outpatient PT/OT/ST	☐	Other	☐
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 ☐ **OP Hospital** ☐ **IP Hospital** ☐ **Free Standing Facility** ☐			
	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.	**PLAN ADMINISTRATIVE USE ONLY:** **Service request status:** **Approved** ☐ **Pending** ☐ **Denied** ☐ **Comments:**			