PRIOR AUTHORIZATION REQUEST FORM

Submit this completed form by fax to **1-833-610-2399,** or on our provider portal:
https://secure.healthx.com/ProCareAdvantage.Provider
Call 1-844-206-3719 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless it is an emergency, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐Routine/Standard ☐Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION			
Member Name:	Member ID:		
Date of Birth:	Member Residence:		
REQUESTING PROVIDER/FACILITY			
Requestor's Name:	Phone Number:	Fax Number:	Date of Request:
Referring Provider (If other than requestor):	Referring Provider: ☐NP/PA ☐PCP ☐Therapy Rep ☐Other		
SERVICING PROVIDER/FACILITY			
Admitting/ Servicing Facility/ Provider Name:			
NPI/ TIN Number:	Phone Number:	Fax number:	
Address:			
City:	State:	Zip:	
SERVICE TYPE REQUESTED			
☐Initial Request ☐ Extension Request, Previous Auth #:			
Outpatient Services (Select one):			
☐ Durable Medical Equipment (DME) ☐Genetic Testing ☐Home Health ☐Imaging/Special Tests ☐Office Procedures	☐Laboratory Services ☐Outpatient Surgical/Procedures ☐Radiation Therapy ☐Transplant/Gene Therapy ☐Transportation	☐PT/OT/ST ☐Wound Care ☐Part B Medication ☐Behavioral Health Services ☐Other	
Days/ Visits/ Units Requested:	Admission Date/ Date of Service:		
CPT/HCPCS Code(s):			
Current Primary Diagnoses and ICD-10 Code (s):			

CLINICAL INFORMATION
• Please submit written documentation from the medical record to support the procedure, including photos when applicable. • Missing this information may delay the decision on your request or may result in Lack of Information denial. • Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.
OUT-OF NETWORK SERVICES ONLY
• Has the service been scheduled already? ☐ Yes ☐ No • Is this a specialized service that no other In-network provider can render? ☐Yes ☐No • Does the member have an established relationship with the provider that should not be interrupted? ☐ Yes ☐No If "Yes", explain (include last visit date):