AmeriHealth Caritas Ohio

Prior Authorization Request Form

Please type this document to ensure accuracy and to expedite processing.
All fields must be completed for the request to be processed.
Please make a selection where applicable throughout the document.

DATE	
TYPE OF REQUEST	_____ URGENT _____ STANDARD _____ RETROSPECTIVE
TREATMENT SETTING	_____ INPATIENT _____ OUTPATIENT
REQUEST TYPE	_____ EXTENSION _____ INITIAL _____ CANCEL _____ CHANGES DOS/SETTING
	_____ ADDITIONAL CLINICAL _____ DISCHARGE PLANNING _____ OTHER
PREVIOUS AUTHORIZATION NUMBER	
CONTACT NAME	
CONTACT PHONE	CONTACT FAX

MEMBER INFORMATION

LAST NAME		
FIRST NAME		
MEMBER ID (MEDICAID ID OR HEALTH PLAN ID)		
MEMBER PHONE NUMBER	DATE OF BIRTH	
MEMBER STREET ADDRESS		
CITY	STATE	ZIP

PROVIDER INFORMATION

PROVIDER NAME			
PROVIDER TIN	PROVIDER NPI		
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER		
PROVIDER STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			
FACILITY NAME			
FACILITY TIN	FACILITY NPI		
FACILITY PHONE NUMBER	FACILITY FAX NUMBER		
FACILITY STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

REFERRING PHYSICIAN NAME (IF DIFFERENT FROM ABOVE)			
REFERRING PHYSICIAN TIN			
REFERRING PHYSICIAN NPI			
REFERRING PHYSICIAN PHONE NUMBER			
REFERRING PHYSICIAN FAX NUMBER			
REFERRING PHYSICIAN STREET ADDRESS			
CITY		STATE	ZIP
PROVIDER STATUS _____ PAR _____ NON PAR _____ IN CREDENTIALING			

MEDICAL SECTION

DIAGNOSIS CODE		

PROCEDURE CODE	START DATE	END DATE	NUMBER OF UNITS	CODE DESCRIPTION

MEDICAL SECTION

NOTES

PLEASE FAX TO **1-833-329-6411**

REMINDER: PROVIDERS ARE RESPONSIBLE FOR OBTAINING PRIOR AUTHORIZATION FOR SERVICES PRIOR TO SCHEDULING THE SERVICE.

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT FOR SERVICES. PAYMENT IS SUBJECT TO BENEFIT COVERAGE RULES, INCLUDING MEMBER ELIGIBILITY, APPLICABLE PROVIDER AGREEMENT PROVISIONS, AND ANY CONTRACTUAL LIMITATIONS IN EFFECT AT THE TIME OF SERVICE.

URGENT MEDICAL CONDITION: ANY ILLNESS, INJURY, OR SEVERE CONDITION WHICH, UNDER REASONABLE STANDARDS OF MEDICAL PRACTICE, WOULD BE DIAGNOSED AND TREATED WITHIN A 24-HOUR PERIOD AND, IF LEFT UNTREATED, COULD RAPIDLY BECOME A CRISIS OR EMERGENCY MEDICAL CONDITION. THE TERM ALSO INCLUDES SITUATIONS WHERE A PERSON'S DISCHARGE FROM A HOSPITAL WILL BE DELAYED UNTIL SERVICES ARE APPROVED OR A PERSON'S ABILITY TO AVOID HOSPITALIZATION DEPENDS UPON PROMPT APPROVAL OF SERVICES.

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