Prior Authorization Request Form
Medical Services and DME Supplies

Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.

☐	Standard Review: (Attach supporting documentation).
☐	Expedited Review: If standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. (Attach supporting documentation)

Please Note: Retroactive requests need to be submitted as a claim

Requestor Information

*Date:_____ Person completing form:_____ *Phone:_____

*Provider/Clinic Name:_____ *Fax:_____

Member Information

*Name:_____ *ID#:_____ *DOB:_____

Requesting Provider Information

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Fax:_____ *Address:_____

Appointment is scheduled for: _____

Delivering Provider / Facility Information

*Name:_____ ICD-10 Code(s):_____

*Address:_____ Phone:_____

Procedure / Service / Item Information

CPT/HCPC & Modifier	Description	Quantity	Start Date	End Date

Surgery Information	☐Outpatient Hospital or ☐ASC	Inpatient: ☐Yes ☐No	
	Date:_____	Admit Date:_____	Discharge Date:_____

Other important information:_____

_____

Fax completed forms with supporting documentation to 1-775-770-3909 for Douglas, Lyon, Storey, Washoe & Carson City Counties in Nevada

THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.