## MEDICAL/BEHAVIORAL HEALTH PRE-AUTHORIZATION AND NOTIFICATION FORM

Please print legibly or type and complete this form in its entirety. Missing information may create a longer processing time. Please FAX this form to The Health Plan: 1.888.329.8471 or 740.695.5297

__Expedited __Routine: *Please note that an expedited request must meet the following criteria: An expedited request is one that by applying the standard time frame for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

| Submitter Name: | Phone Number: |
|---|---|
| **MEMBER (PATIENT) INFORMATION** | |
| Name: | Date of Birth: |
| The Health Plan ID#: | PCP Name: |
| **PROVIDER INFORMATION** | |
| Requesting Physician/Provider | Servicing Provider/Facility/Physician |
| Name: | Name: |
| Specialty: | Specialty: |
| Address: | Address: |
| Phone Number: | Phone Number: |
| FAX Number: | FAX Number: |
| NPI Number: | NPI Number: |
| **SERVICES REQUESTED** | |
| | |
| | |
| | |
| **DIAGNOSES (List of Codes & Descriptions)** | |
| 1. | 2. |
| 3. | 4. |
| **PROCEDURE/SERVICE (List all CPT/HCPCS Codes and Descriptions-Required)** | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| Date(s) of Service: | # of Units/Visits: |
| If service is requested to a tertiary/out of plan network/non-network provider, explain why service cannot be provided in plan or in network: | |
| | |
| **YOU MUST ATTACH ALL SUPPORTING CLINICAL INFORMATION** (e.g. consultations, significant medical history, significant surgical history, lab reports, progress notes, clinical records/office notes) **PLEASE NOTE: DEPENDING ON THE INFORMATION YOU SUBMIT WE MAY REQUEST FURTHER PATIENT SPECIFIC INFORMATION TO PROCESS THIS REQUEST.** | |