

**PRIOR AUTHORIZATION REQUEST FORM**

**Please read all instructions prior to completing this form.**

**Do not use this form:**

- 1.) To request an appeal.
- 2.) To confirm eligibility.
- 3.) To verify coverage.
- 4.) To ask whether a service requires prior authorization.
- 5.) To request prior authorization of a prescription drug.

**Addition information and instructions:**

Section IV

- If the *Request Provider* or *Facility* will also be the *Service Provider* or *Facility*, enter "Same".
- If the patient's plan requires them to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same".

Section VI

- Attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.), if needed.

**Prior Authorization Request Form**  
**Section I --- Submission**



Requestor Name	Phone	Fax
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**Section II --- General Information**

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent Yes No If urgent, I attest the clinical supports urgency.	Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Concurrent
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**Section III --- Patient Information**

Name	Patient Contact Phone	DOB	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary
Subscriber Name (if different)		Member ID#	Group #

**Section IV --- Provider Information**

<i>Requesting Provider or Facility</i>			<i>Service Provider or Facility</i>		
Name			Name		
NPI#	TIN#	Specialty	NPI#	TIN#	Specialty
Phone	Fax		Phone	Fax	
Contact Name and Phone			Name of Primary Care Provider (see instructions)		
			Phone	Fax	

**Section V --- Services Requested (with CPT or HCPCS Code) and Supporting Diagnoses (with ICD10 Code)**

Planned Service or Procedure	Code	Unit	Start Date	End Date	Diagnosis Description (ICD10 Version __), if available

Inpatient  Outpatient  Provider Office  Observation  Home  Other (specify) \_\_\_\_\_

Inpatient Level of Care:  
 SNF  LTAC  Medical Rehab  MH  CD  Residential  Inpatient

Outpatient Level of Care:  
 Physical Therapy  Occupation Therapy  Speech Therapy  Mental Health/Substance Abuse  IOP  
 Number of sessions \_\_\_\_\_ Duration \_\_\_\_\_ Frequency \_\_\_\_\_ Other \_\_\_\_\_

Home Health Care:  
 Nursing  PT  ST  OT  SNV  HHA  SW  Infusion  
 Number of visits requested \_\_\_\_\_ Duration \_\_\_\_\_ Frequency \_\_\_\_\_ Other \_\_\_\_\_

DME: (MD signed ordered attached? Yes No)  
 Equipment/Supplies \_\_\_\_\_  
 HCPCS Codes \_\_\_\_\_ Duration \_\_\_\_\_

**Section VI --- Clinical Documentation (See Instructions Page, Section VI)**

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If more information is needed, OhioHealthy may call the requesting provider or authorized representative directly at:

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