



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.			