**PRIOR AUTHORIZATION REQUEST FORM**

**<u>Please read all instructions</u> 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:**

<u>Section IV</u>

- 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".

<u>Section VI</u>

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

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

OhioHealthy

| Requestor Name | Phone | Fax |
|---|---|---|
| | | |

**Section II --- General Information**

| | |
|---|---|
| Review Type: ☐ Non-Urgent ☐ Urgent<br>☐ Yes ☐ No If urgent, I attest the clinical supports urgency. | Request Type: ☐ Initial Request ☐ Concurrent |

**Section III --- Patient Information**

| Name | Patient Contact Phone | DOB | Sex: ☐ Male ☐ Female ☐ Non-Binary |
|---|---|---|---|
| Subscriber Name (if different) | | Member ID# | Group # |

**Section IV --- Provider Information**

| *Requesting Provider or Facility* | | | *Service Provider or Facility* | | |
|---|---|---|---|---|---|
| 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:
_____.

Phone: 833-865-1190 Fax: 717-295-1208