Prior authorization supporting documentation cover sheet

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Fax: 1-877-940-3604

Phone: Indiana: 1-866-565-3361

Ohio: 1-866-566-4715

New York: 1-866-565-3468

Requestor contact: ____

____

Phone:____________________________________Ext:______________

Fax: ____

IMPORTANT: Complete all fields on this form to ensure timely review.

Supporting documentation for existing prior authorization requests

Attach clinical information to support prior authorization request (e.g., plan of care, medical records, lab reports, letter of medical necessity, progress notes, etc.).

Case ID: ____

Patient name: ____ DOB: ______________

Comments:

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

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