

Prior Authorization Request Form



Fax Requests to 1-833-263-4869

Patient Name: _____

MediGold Member ID: _____

Patient's Date of Birth: ____/____/____

Patient's Phone: _____

Please select service(s) for which you are requesting prior authorization.

Home Health Care

BRAC gene testing

Integrated Oncology/Radiation Therapy

Power Operated Vehicles (CMN required)

Durable Medical Equipment (DME)

Inpatient Rehabilitation/Long Term Acute Care Admit

Part B Therapy

Part B Drugs/Chemotherapy Drugs

Transplant Evaluation or Transplant

Hyperbaric Oxygen

Other: _____

Elective Procedure: please select expected bed type below

Inpatient

Observation

Outpatient

Requesting Provider's Name: _____

Provider's Phone: _____ Provider's Fax: _____

Name of Person Completing Request: _____ Contact Phone: _____

Servicing Facility (if applicable): _____

Facility NPI: _____ Facility TIN: _____

Servicing Provider: _____

Provider NPI: _____ Provider TIN: _____

Provider's Phone: _____ Provider's Fax: _____

Start Date _____ **Frequency** _____

Applicable Diagnoses & ICD-10 Codes: _____

Service Description and Code(s): _____

Medical Rationale for Request: _____

OUT-OF-NETWORK CARE for HMO Members (does not apply for PPO members): Out-of-network care is only considered when services are not accessible in-network.

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Expedited

Read Definition below prior to checking box
Check expedited **ONLY** if it meets the definition of expedited request per CMS Guideline 50 - **Expedited Organization** Determination: Enrollee/Physician believes that waiting for a decision under the standard time frame (14 days) could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

IDN Review