Medical Prior Authorization Form

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Insurance ID: _____ Group Number: _____

Policyholder's Name (if different): _____

PROVIDER INFORMATION

Healthcare Provider's Name: _____ National Provider Identifier: _____

Address: _____ Phone Number: _____

Fax Number: _____

AUTHORIZATION REQUEST DETAILS

Date of Request: _____ dd / mm / yyyy Procedure / Service Requested: _____

CPT Code: _____ Diagnosis Code: _____

Requested Start Date: _____ dd / mm / yyyy Anticipated Duration of Treatment: _____

Clinical Justification:

PRESCRIBING PHYSICIAN'S INFORMATION (IF APPLICABLE)

Physician's Name: _____ National Provider Identifier: _____

DEA Number (if applicable): _____ Phone Number: _____

PATIENT CONSENT

I, the undersigned, understand that the requested procedure or service is subject to prior authorization by my insurance provider. I authorize the release of any necessary medical information for the purpose of obtaining this authorization.

Patient's Signature:

Date: _____ dd / mm / yyyy

PROVIDER'S CERTIFICATION

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that providing false information may result in denial of the authorization request.

Provider's Signature:

Date: _____ dd / mm / yyyy

Please attach any supporting documentation such as medical records, test results, or physician notes for clinical justification.