130 DeSiard Street, Ste.300 Monroe, LA 71201 Ph. 318-361-0900 Fax 318-361-2170

PRIOR AUTHORIZATION FORM

Date: ______________________________

To: Medical Management Department

Fax Number: 318-361-2170

Pt. Name: ______________________________

Insured ID: ______________________________

☐ Medicare

☐ Commercial

☐ Marketplace

Pt. DOB: ______________ Age: ______________

PCP: ______________________________

Date of Service: ______________________________

Ordering MD: ______________________________

Provider's NPI: ______________________________

Date of Service: ______________________________

Place of Service:______________________________

Facility NPI:______________________________

Diagnosis: ______________________________

____

Provider's Name: ______________________________

Fax #: ______________________________

Phone Number: ______________________________

Contact:______________________________

Prior Authorization #: ______________

[ ] Outpatient [ ] Inpatient

ICD-10 Code:________________________

____

Procedure to be performed:____

CPT codes to be billed: ______________, ______________, ______________, ______________, ______________,

HCPC codes to be billed: ______________, ______________, ______________, ______________

Attachments are to be included at all times, when available:

[ ] Diagnostic Procedures: Clinical Notes or Diagnostic Reports for procedure /surgery

[ ] Admission: Clinical for planned admissions

[ ] DME: Physician's Order, CMN, Sleep Study, Compliance Report, Clinical Notes

[ ] DME: Date of Service when equipment was issued to patient: ______________________________

[ ] Therapy: Physician's Order, Evaluation, or Clinical notes

FOR EXPEDITED REVIEW [72 HOURS] REQUEST ONLY:

BY SIGNING BELOW, I AM REQUESTING AN EXPEDITED REVIEW AND CERTIFYING THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

SIGNATURE OF PHYSICIAN:____