

Prior authorization request form

You must have a valid PROMISE ID (i.e., participate in the Pennsylvania Medicaid programs) at the time the service is rendered in order for your claim to be paid. For more information, please visit <https://promise.dpw.state.pa.us>. Please only submit this form with supporting clinical.

SERVICE(S) REQUESTED: Please PRINT LEGIBLY or TYPE.

MEMBER INFORMATION	
Name:	PCP Name:
DOB:	Other insurance:
Member ID#:	Other insurance Policy Number:
Gender (circle one): M or F	
PROVIDER INFORMATION (Ordering and/or Rendering Providers)	
Ordering Physician/Nurse Practitioner:	Rendering Provider/Facility/Physician:
Name:	Name:
Address:	Address:
Tel:	Tel:
*Fax (REQUIRED):	*Fax (REQUIRED):
Contact Person:	Specialty:
NPI:	NPI:
PROMISE ID:	PROMISE ID:
REQUIRED CLINICAL INFORMATION	
INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> HOME HEALTH <input type="checkbox"/> DME <input type="checkbox"/> PHYSICAL/OCCUPATIONAL/SPEECH THERAPY <input type="checkbox"/> OTHER <input type="checkbox"/>	
Diagnoses (list CODES & description):	
1.	3.
2.	4.
*NDC Code (REQUIRED for pharmacy requests)	
1.	3.
2.	4.
Procedure/service requested (list all CPT/HCPCS codes & descriptions required)	
1.	4.
2.	5.
3.	6.
Date(s) of service:	# of units/visits:
For Home Health (shift care) ONLY:	
Number of hours per day:	Number of days per week:

REQUIRED DOCUMENTATION
Please attach supporting clinical information (e.g., Plan of Care, medical records, lab reports, letter of medical necessity, progress notes, etc.). In order for the member to receive requested services in a timely manner, be sure to provide ALL supporting documentation with the request. IF THIS IS A REQUEST FOR THERAPY, PLEASE USE A SEPARATE FORM FOR EACH SERVICE! (e.g., one form for PT with all codes and clinical, one form for OT with all codes and clinical etc.)

Questions? Call Provider Relations at 1-866-638-1232. FAX form to: 1-877-363-8120.