



## PRIOR APPROVAL FOR MEDICAL SERVICES

MAIL COMPLETED FORMS TO:

Please provide written answers or check appropriate box. Type or print legibly. Where additional space is needed, please attach supplemental sheet(s).

1. PHYSICIAN'S NAME OR AGENCY NAME		2. PROVIDER #		3. <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> D.P.M.	
ADDRESS			TELEPHONE		
4. MEMBERS NAME			5. MEMBER ID NUMBER		6. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
7. ADDRESS				8. DATE OF BIRTH	
9. HOSPITAL					
10. DIAGNOSIS					
11. DATE MEMBER FIRST SEEN FOR ABOVE DIAGNOSIS				12. MOST RECENT VISIT	
13. MEMBERS PRESENT MEDICAL STATUS					
14. TREATMENT OR SERVICES RENDERED					
15. DATE AND RESULTS OF LAB PROCEDURES AND/OR X-RAYS					
16. OPERATION, PROCEDURE, TREATMENT, OR SERVICE FOR APPROVAL				Procedure/Code	Estimated Price Per Unit
Description					Units of Service
1					
2					
3					
4					
17. PLAN OF CARE					
18. JUSTIFICATION FOR REQUESTING #16.					
19. PHYSICIAN'S SIGNATURE			20. DATE		
DATE			SIGNATURE		

\* Prior approval applies only to this member unless otherwise specified. The approval applies only if the member is eligible at the time the services are rendered.

\*\*This request is subject to Retrospective Peer Review.