



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.		
ADDRESS		TELEPHONE		<input type="checkbox"/> D.O.		
				<input type="checkbox"/> D.P.M.		
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	Units of Service
Description						
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.