MEDICAL SERVICE Prior Authorization Form

FAX: 1-844-457-8942

www.stewardhcgenerations.org/ut

Steward Health Care Network

HEALTH CHOICE GENERATIONS

Ordering Providers are required to send medical documentation supporting the requested service.

Member Name (Last, First)	Member ID#	DOB	Date of Request
Ordering Provider Name	NPI#	TIN#	
Office Contact Person	Direct Phone #	Fax #	
Diagnosis 1 (ICD-10 code)	Diagnosis 2 (ICD-10 code)	Diagnosis 3 (ICD-10 code)	

- **STANDARD** (up to 14 calendar days).....No Signature Required.
- **EXPEDITED** (up to 72 hours).....**By signing below, you are requesting expedited processing and that the request fits into one of the two categories below.**
  - **Processing within the standard timeframe will jeopardize the life or health of the member and impact ability to regain maximum function.**
  - **Processing within the standard timeframe will cause a barrier to transition of care**

Therefore, you are certifying, as the ordering provider, that applying the standard review time frame may seriously jeopardize the member's life, health or ability to regain maximum function.

Ordering Provider Signature	Date

☐ Inpatient ☐ Outpatient ☐ ASC ☐ Office	Specialist Name (Last, First)	Specialty	
Name of Facility (if applicable)		Date of service	
Address	NPI#	TIN#	Phone #
Name of Procedure	CPT code 1	CPT code 2	CPT code 3	CPT code 4

☐ Physical Therapy	☐ Occupational Therapy	☐ Speech Therapy	☐ Home Health	☐ Office
_____# of visits/units	_____# of visits/units	_____# of visits/units	_____# of visits/units	_____# of visits

Contracted Ancillary Service Request (DME; O&P; Equipment) and HCPCS Code (or attach list of codes)

Medication Request for Administration for Physician Office Administration

Name of Medication (and J-code)	Dosage	Quantity/Amount	Refills (<12)
Sig/Instructions	Allergies		
List Medications Tried/When			
List Medications Contraindicated/Reason			
Provider Signature		Date	

Updated on 02/06/19