Confidential **PRIOR AUTHORIZATION FORM** *Confidential*

Complete Entire Form and Fax to: (586)693-4829

□ Please email photographs only to: mcacaremgt@abs-tpa.com

Requesting Provider Information:

Request Date: _____ □ **Elective**

Contact Name: _____ □ **Direct/Urgent**

Phone #: _____ □ **Emergent**

FAX #: _____

REQUESTING PROVIDER: _____

SPECIALTY: _____

PATIENT NAME: _____**PATIENT DOB:** _____

Subscriber Name: _____ **Subscriber ID#:** _____

Requested Service(s):

REQUESTED PROVIDER: _____

ADDRESS: _____

NPI#: _____

Phone #: _____ **Fax #:** _____

FACILITY (if applicable): _____□ **Inpatient** □ **Outpatient**

ADDRESS: _____

NPI#: _____

Phone #: _____ **Fax #:** _____

□ **PROPOSED DOS:** _____

DIAGNOSIS: 1_____**ICD-10 CODE:** _____

2_____**ICD-10 CODE:** _____

PROCEDURE: 1_____**CPT4 CODE:** _____

PROCEDURE: 2_____**CPT4 CODE:** _____

Relevant Clinical Information: Please attach (if mailing) or fax all applicable clinical information.

(signs, symptoms, history, diagnostic test results, consultant recommendations (if applicable), plan of treatment)

DO NOT WRITE BELOW THIS LINE FOR OFFICE USE ONLY

Authorized Service(s): **CPT4 Code:** _____

Other: _____

Comments/Instructions:

_____

_____

_____

Authorization is limited to the services described above.

AUTHORIZATION #: _____**Expire Date:** _____

(Prior authorization approval is not a guarantee that a claim will be paid in full, as there may be other reasons to deny claim)