



**Prior Authorization Fax Form**  
 Complete this Form and Fax to 1-866-614-1950  
 Incomplete Forms Will Be Returned for Resubmission

- Standard Request**-(determination within 2 working days of receiving all necessary information)  
 **Urgent Request** – By checking this box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening) which must be treated within 24 hours.  
**ALL URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN, IN ORDER TO BE PROCESSED AS AN URGENT REQUEST**

\_\_\_\_\_  
**Signature of Requesting Provider**

**Requesting Provider Name:** \_\_\_\_\_ **Requesting Provider Tel:** \_\_\_\_\_  
**Requesting Provider Fax:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

**Patient Information**

<b>Name (Last, First, Middle Initial):</b>	<b>Date of Birth:</b>
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**Member Medicaid ID#**

**Other Insurance? (if Yes) Name and Policy #:**

**- Must Be Completed -**

Referring To Specialist and /or Facility:  Participating  Non-Participating

<b>Specialist / Facility Name:</b>	<b>Specialty / Facility Type:</b>
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**Address/Location:**

<b>City:</b>	<b>Zip:</b>	<b>Telephone:</b>
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**Purpose of Referral:**

<input type="checkbox"/> Consult Only	<input type="checkbox"/> Diagnostic / Radiology	<input type="checkbox"/> Therapy PT/OT/ST
<input type="checkbox"/> Consult w/Treatment	<input type="checkbox"/> Outpatient Surgery	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Follow-up Visit	<input type="checkbox"/> Inpatient Admission	
<input type="checkbox"/> Consult & Follow-up Visit		

PLEASE SEND WITH THIS FORM COPIES OF APPROPRIATE SUPPORTING CLINICAL INFORMATION FOR ALL CASES

<b>Diagnosis / Reason:</b>	<b>ICD-9 Code(s):</b>
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<b>Service/Procedure Requested/CPT Code:</b>	<b>Requested Dates of Service:</b>
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**TO BE USED BY HEALTH PLAN STAFF**

<b>Approved:</b> _____ <b>Units approved:</b> _____ <b>Authorization Number:</b> _____ <b>Authorization Start Date:</b> _____ <b>Authorization End Date:</b> _____	<b>Decision Date:</b> _____ <b>Reviewer:</b> _____
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<b>Denied</b> _____	<b>Prior Authorization Dept. Phone Number</b> 1-866-895-1786
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**Disclaimer:** Authorization is contingent upon the following: At the time services are rendered, beneficiary is eligible for services and services are a covered CeltiCare Health Plan Benefit. An authorization is not a guarantee of payment. All services must be coordinated by the Primary Care Physician. **Please mail or fax a copy of the consultation/follow up report to the PCP within 7-10 business days of visit.**

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.