

Prior Authorization Request Form



Patient Information

Name (First, MI, Last):	DOB:	Gender:	Member ID Number:
Address:			
Patient E-mail Address:	Telephone Number:		
Employer/Group Name:		Employer/Group Number:	

Provider Information (Requesting/Servicing)

Requesting Physician:	Phone Number & Extension:	Fax Number:
Address:	NPI Number:	Tax ID Number:
Servicing Facility (where services will be rendered):	Phone Number & Extension:	Fax Number:
Address:	NPI Number:	Tax ID Number:

Contact Name (person completing this form):	Phone Number & Extension:	Are you with Requesting or Servicing provider:
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Authorization Request Information

Case Type	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Outpatient
Medical, Surgical, Obstetrics, MH, SA, Diagnostic, Continuing Care		
Urgency	<input type="checkbox"/> Elective	<input type="checkbox"/> Emergent
Date(s) of Service	Medical Record #:	

REQUIRED FOR ALL REQUESTS: ICD-10 Code(s) & Description

REQUIRED FOR ALL PROCEDURES/DIAGNOSTICS: CPT Codes(s), description, Date

Description of symptoms:
Prior treatment provided (i.e., PT, NSAIDS):
Related labs/diagnostic studies results (i.e., X-rays, ultrasound labs):

Benefits are subject to eligibility and all HealthChoice policy provisions at the time services are incurred.

Send completed form and supplemental clinical to Level3@ahhinc.com or fax number (855) 532-6780

Please note - Case will not be initiated without completed form and supplemental clinical.