# Prior Authorization Request Form

HealthChoice

## 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: |
|---|---|---|
| | | |

## Authorization Request Information

| Case Type | ☐ Inpatient ☐ Outpatient |
|---|---|
| Medical, Surgical, Obstetrics, MH, SA, Diagnostic, Continuing Care | |
| Urgency | ☐ Elective ☐ Emergent |
| Date(s) of Service | Medical Record #: |

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

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

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| 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.**