

PRIOR AUTHORIZATION REQUEST

Please Fax To Inpatient 234-542-0811. Radiology, Radiation Oncology, Medication Oncology, Lab And Genomic Testing 800-540-2406. All Other 234-542-0815.

In Order For This Request To Be Processed, This Form Must Be Completed In Its Entirety And Clinical Information Must Be Attached. *For Urgent Request Only, Please Call 330-996-8710 Or 888-996-8710.

Member Last Name: Middle Initial: ORDERING PHYSICIAN INFORMATION Physician Last Name: Physician First Name: Physician Last Name: Physician First Name: Physician First Name: Physician First Name: Physician First Name: Nex Buttersion: State: Zip: Colspan="4">Zip: Co	Date:	Member ID#:			Member DOB: Member			Phone #:		
Physician Last Name: Physician First Name: Physic	Member Last Name:			Member First Name:					Middle Initial:	
NPI #: Tax ID #: Address: City: State: Zip Code: Phone #: Phone # Optional Extension: Other Contact Name: Fax #: PROCEDURE ORDER *Has the service being requested already been performed? Yes No Date of Service: Diagnosis: CPT Code(s): ICD-10 DX Code: Elective Admission Out-of-Network Referral Other Genetic Testing Only): ADDITIONAL INFORMATION Service Requested/Additional Notes: Outpatient Surgery Address: Attending Physician Last Name: NPI #: Address: Attending Physician Last Name: NPI #: Tax ID #: Address: State: Zip Code:	ORDERING PHYSICIAN INFORMATION									
Address: City: State: Zip Code: Phone #: Phone # Optional Extension: Other Contact Name: Fax #: PROCEDURE ORDER *Has the service being requested already been performed? Yes No Date of Service: Diagnosis: CPT Code(s): ICD-10 DX Code: Elective Admission Imaging Out-of-Network Referral Other Physician's Signature (Genetic Testing Only): ADDITIONAL INFORMATION Service Requested/Additional Notes: Outpatient Surgery Outpatient FACILITY/PROVIDER INFORMATION FACILITY/PROVIDER INFORMATION Address: Attending Physician Last Name: NPI #: Address: State: Zip Code:	Physician Last Name:			Physician First Name:						
Phone #: Phone # Optional Extension: Other Contact Name: Fax #: PROCEDURE ORDER *Has the service being requested already been performed? Yes No Date of Service: Diagnosis: CPT Code(s): ICD-10 DX Code: Elective Admission Outpatient Surgery Out-of-Network Referral Outpatient Signature (Genetic Testing Other Physician's Signature (Genetic Testing Only): ADDITIONAL INFORMATION Service Requested/Additional Notes: Outpatient Facility: Address: Attending Physician Last Name: Attending Physician First Name: NPI #: Tax ID #: Address: Zip Code:	NPI #:			Tax ID #:						
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*Has the service being requested already been performed? Yes No Date of Service: CPT Code(s): Elective Admission	Other Contact Name:			Fax #:						
Date of Service: CPT Code(s): ICD-10 DX Code: Elective Admission	PROCEDURE ORDER									
CPT Code(s): CD-10 DX Code: Elective Admission	*Has the service being requested already been performed?				Yes No					
Elective Admission Imaging Genetic Testing Out-of-Network Referral Other Physician's Signature (Genetic Testing Only): ADDITIONAL INFORMATION Service Requested/Additional Notes: FACILITY/PROVIDER INFORMATION Name of Facility: Address: Attending Physician Last Name: NPI #: Address: City: State: Zip Code:	Date of Service:			Diagnosis:						
Imaging Genetic Testing Out-of-Network Referral Other Physician's Signature (Genetic Testing Only): ADDITIONAL INFORMATION Service Requested/Additional Notes: Outpatient Inpatient FACILITY/PROVIDER INFORMATION Name of Facility: Address: Attending Physician Last Name: NPI #: Address: City: State: Zip Code:	CPT Code(s):			ICD-10 DX Code:						
Genetic Testing Other Physician's Signature (Genetic Testing Only): ADDITIONAL INFORMATION Service Requested/Additional Notes: Outpatient Inpatient FACILITY/PROVIDER INFORMATION Name of Facility: Address: Attending Physician Last Name: NPI #: Address: City: State: Zip Code:	Elective Admission			Outpatient Surgery						
Physician's Signature (Genetic Testing Only): ADDITIONAL INFORMATION Service Requested/Additional Notes: FACILITY/PROVIDER INFORMATION Name of Facility: Address: Attending Physician Last Name: NPI #: Address: City: State: Zip Code:	Imaging			Out-of-Network Referral						
ADDITIONAL INFORMATION Service Requested/Additional Notes: FACILITY/PROVIDER INFORMATION Name of Facility: Address: Attending Physician Last Name: NPI #: Address: City: State: Zip Code:	Genetic Testing			Other						
Service Requested/Additional Notes: FACILITY/PROVIDER INFORMATION Name of Facility: Address: Attending Physician Last Name: NPI #: Tax ID #: Address: Zip Code:	Physician's Signature (Genetic Testing Only):									
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FACILITY/PROVIDER INFORMATION Name of Facility: Attending Physician Last Name: NPI #: Address: Tax ID #: Address: Zip Code:	Service Requested/Additional Notes:									
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Name of Facility: Attending Physician Last Name: Attending Physician First Name: NPI #: Tax ID #: Address: Zip Code:									Inpatient	
Name of Facility: Attending Physician Last Name: Attending Physician First Name: NPI #: Tax ID #: Address: Zip Code:										
Attending Physician Last Name: NPI #: Address: Attending Physician First Name: Tax ID #: State: Zip Code:	FACILITY/PROVIDER INFORMATION									
NPI #: Tax ID #: Address: City: State: Zip Code:	Name of Facility:			Address:						
Address: City: State: Zip Code:	Attending Physician Last Name:				Attending Physician First Name:					
	NPI #:				Tax ID #:					
Phone #: Fax #:	Address: City:				State: Zi		p Code:			
	Phone #:				Fax #:					

CLINICAL INFORMATION – PERTINENT TO PROVIDER SERVICE (ATTACH COPIES OF PERTINENT CLINICALS) Include symptoms/findings, medications, labs, tests, imaging and conservative treatment (if any).

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and privileged information for the use of the designated recipients. If you are not the intended recipient, you are hereby notified that you have received this communication in error and any review, disclosure, distribution, or copying of it or its contents is prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at 1200 E.

Market St., Suite 400, Akron, OH 44305 via the USPS. If this was an email received in error, please notify the sender and delete it.