



## PRIOR AUTHORIZATION FORM

Date: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Tel.#: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Referring Specialty Physician: \_\_\_\_\_  
Referral to Extended Network/Non-Participating Specialist: \_\_\_\_\_  
Specialist Tel.#: \_\_\_\_\_ Specialist Fax#: \_\_\_\_\_  
Facility: \_\_\_\_\_ Ancillary Provider: \_\_\_\_\_

**NOTE:** Prior approval is required for all facility, ancillary provider, extended network, and non-network services, except in the case of emergencies. Failure to receive prior approval will result in denial of health care claims.

\_\_\_\_\_ Consult Only Appointment Date: \_\_\_\_\_  
\_\_\_\_\_ Consult and Treat - # of Visits \_\_\_\_\_ (Maximum of 4 within 180 days)  
\_\_\_\_\_ In-Patient Procedures(s): \_\_\_\_\_ Date Scheduled: \_\_\_\_\_  
\_\_\_\_\_ Out-Patient Procedures(s): \_\_\_\_\_ Date Scheduled: \_\_\_\_\_  
\_\_\_\_\_ Physical Therapy: (# visits) \_\_\_\_\_ Occupational Therapy: (#visits): \_\_\_\_\_  
\_\_\_\_\_ Speech Therapy: (# visits) \_\_\_\_\_ Cardiac Rehab: (#visits): \_\_\_\_\_  
\_\_\_\_\_ Treatment (e.g., Chemo, Rad.) Type of Treatment: \_\_\_\_\_  
\_\_\_\_\_ Home Health – (# of visits) \_\_\_\_\_ (Maximum of 7 within 14 days or 14 within 28 days)  
\_\_\_\_\_ DME –List Items, HCPCS Code, if known: \_\_\_\_\_  
\_\_\_\_\_ Pain Management - Specialist Name \_\_\_\_\_ # of visits: \_\_\_\_\_  
\_\_\_\_\_ Other: Describe: \_\_\_\_\_  
Diagnosis/ ICD-9 Code: \_\_\_\_\_  
Reason for Referral: \_\_\_\_\_  
Fax This Form to:  
Health Plan Select Fax: (706) 208-0024 or (800) 327-2004  
PCP Name: \_\_\_\_\_ Fax#: \_\_\_\_\_

If you have any questions, please call the Quality/Utilization Management Department at (706) 549-0549.

TOP COPY: PHYSICIAN

BOTTOM COPY: PATIENT

*Submission of this form is not a guarantee of benefits or claim payment and does not constitute an approval. Authorizations will be forthcoming as appropriate.*