PO BOX 1296
Riverside, CA 92502
(909) 461-1515

Prior Authorization Request Form **Fax (877) 471-5478**

Request: Retro ☐	Routine ☐	Urgent ☐	**Request Date:**

Patient Information

First Name:	Last Name:	MI:	DOB:	☐ Male ☐ Female
Address:	City:	State:	Zip:	
Insurance Name:	Patient ID Number:			

Requesting Provider Information

Provider Name:	NPI:		
Organization:	Org Phone:	Org Fax:	
Address:	City:	State:	Zip:
Contact Person:	Contact Phone:	Contact Fax:	

Referring to Provider Information and Facility

Provider Name:	NPI:		
Organization:	Org Phone:	Org Fax:	
Address:	City:	State:	Zip:
Contact Person:	Contact Phone:	Contact Fax:	
Place of Service / Facility:	Facility Phone:	Facility Fax:	

Diagnosis and Medical Necessity

ICD 10:	Diagnosis description:
ICD 10:	Diagnosis description:
ICD 10:	Diagnosis description:

Requested Services

CPT:	Description of Service:	Quantity:
CPT:	Description of Service:	Quantity:
CPT:	Description of Service:	Quantity:
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Providers must verify member eligibility to ensure coverage.
To ensure timely decision making, please attach clinical notes with authorization request.
Claims for services rendered without required prior authorization may be denied reimbursement.