Medical Prior Authorization Form

Patient Information	
Name:	Date of Birth:
Insurance ID:	Group Number:
Policyholder’s Name (if different):	
Provider Information	
Healthcare Provider’s Name:	National Provider Identifier:
Address:	
Phone Number:	Fax Number:
Authorization Request Details	
Date of Request:	Procedure / Service Requested:
CPT Code:	Diagnosis Code:
Requested Start Date:	Anticipated Duration of Treatment:
Clinical Justification	
Prescribing Physician’s Information (if applicable)	
Physician’s Name:	National Provider Identifier:
DEA Number (if applicable):	Phone Number:

Patient Consent	
I, the undersigned, understand that the requested procedure or service is subject to prior authorization by my insurance provider. I authorize the release of any necessary medical information for the purpose of obtaining this authorization.	
Patient’s Signature	**Date**
Provider’s Certification	
I certify that the information provided is accurate and complete to the best of my knowledge. I understand that providing false information may result in denial of the authorization request.	
Provider’s Signature	**Date**
Please attach any supporting documentation such as medical records, test results, or physician notes for clinical justification.	