



## Prior authorization request form

You must have a valid PROMISe ID (i.e., participate in the Pennsylvania Medicaid programs) at the time the service is rendered in order for your claim to be paid. For more information, please visit <https://promise.dpw.state.pa.us>. Please only submit this form with supporting clinical.

**SERVICE(S) REQUESTED:** Please PRINT LEGIBLY or TYPE.

MEMBER INFORMATION	
Name:	PCP Name:
DOB:	Other insurance:
Member ID#:	Other insurance Policy Number:
Gender (circle one): M or F	
PROVIDER INFORMATION (Ordering and/or Rendering Providers)	
<b>Ordering</b> Physician/Nurse Practitioner:	<b>Rendering</b> Provider/Facility/Physician:
Name:	Name:
Address:	Address:
Tel:	Tel:
<b>*Fax (REQUIRED):</b>	<b>*Fax (REQUIRED):</b>
Contact Person:	Specialty:
NPI:	NPI:
PROMISe ID:	PROMISe ID:
REQUIRED CLINICAL INFORMATION	
INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> HOME HEALTH <input type="checkbox"/> DME <input type="checkbox"/> PHYSICAL/OCCUPATIONAL/SPEECH THERAPY <input type="checkbox"/> OTHER <input type="checkbox"/>	
Diagnoses (list <b>CODES</b> & description):	
1.	3.
2.	4.
<b>*NDC Code (REQUIRED for pharmacy requests)</b>	
1.	3.
2.	4.
Procedure/service requested (list all CPT/HCPCS codes & descriptions required)	
1.	4.
2.	5.
3.	6.
Date(s) of service:	# of units/visits:
<b>For Home Health (shift care) ONLY:</b>	
Number of hours per day:	Number of days per week:

REQUIRED DOCUMENTATION
Please attach supporting clinical information (e.g., Plan of Care, medical records, lab reports, letter of medical necessity, progress notes, etc.). <b>In order for the member to receive requested services in a timely manner, be sure to provide ALL supporting documentation with the request.</b> <b>IF THIS IS A REQUEST FOR THERAPY, PLEASE USE A SEPARATE FORM FOR EACH SERVICE!</b> (e.g., one form for PT with all codes and clinical, one form for OT with all codes and clinical etc.)

**Questions? Call Provider Relations at 1-866-638-1232. FAX form to: 1-877-363-8120.**