



CONFIDENTIAL
CONTAINS PROTECTED HEALTH INFORMATION

REQUEST FOR PRIOR AUTHORIZATION (PA)

Must be completed by provider for request to be processed

Today's date: _____ Member Name: _____
Date of Birth: _____ SS #: _____ Phone #: _____
Diagnosis: _____ ICD-9: _____
Procedure: _____
CPT-4: _____ Date Scheduled: _____
Facility _____
PA Contact : _____ Phone _____
FAX #: _____

Please check appropriate box:

- | | |
|---|---|
| <input type="checkbox"/> Pharmacy Prior Authorization | <input type="checkbox"/> Air Transport |
| <input type="checkbox"/> Wound Vac | <input type="checkbox"/> Non-emergent transport |
| <input type="checkbox"/> Orthotics/Prosthetics | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Elective Inpatient Procedure | <input type="checkbox"/> Outpatient Procedure |
| <input type="checkbox"/> Request for pre-op day or a one-day length of stay | |

This is a notification of change in services? Yes No

Procedure Code: _____ Description: _____
Procedure Code: _____ Description: _____
Procedure Code: _____ Description: _____
Procedure Code: _____ Description: _____
Comments: _____

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by iCare. A patient may become ineligible for iCare benefits during the term of this prior authorization. Please fill out this form completely. An incomplete form may delay processing and/or claims payment.

FOR iCare USE ONLY:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Medicare iCare | <input type="checkbox"/> Medicare Other | <input type="checkbox"/> Medicaid iCare | <input type="checkbox"/> Medicaid Other | |
| <input type="checkbox"/> Approved | <input type="checkbox"/> Modified | <input type="checkbox"/> Returned | <input type="checkbox"/> Denied | <input type="checkbox"/> No PA Required |
| <input type="checkbox"/> Progress Notes Required | | | | |

Comments: _____

Authorization Coordinator: _____ RNCM: _____
Date Received: _____ Entered By: _____ Date Entered: _____
Authorization #: _____ Care Coordinator _____
Medical Director Signature: _____ Date: _____