



Medical Prior Approval or Out of Network Request Form

Instructions: Please fill out this form completely and fax to 517.364.8409, Monday-Friday, 8am-5pm, except holidays
 Documentation that must be submitted with the request includes:

- ✓ Clinical documentation that supports the need for the service(s)
- ✓ Clinical documentation that supports the need for the service(s) to be performed out-of-network
- ✓ Consult report from the in-network specialist who evaluated the member for the requested service
- ✓ Any other pertinent information for the review of this request.

Patient Information		Referring Prescriber Information	
Today's date:		Referring Provider name:	
Member name:		Office phone:	Fax:
Member's PHP ID#:		Office contact:	
Date of birth:		Patient's Primary Physician:	
Out of Network Provider/Facility Information (if applicable)			
Out of Network Provider name:		Specialty:	
Phone #:		Fax #:	
Address: <i>(include city, state, zip)</i>		Out of network contact person:	
If the request is a procedure , and will be performed at a facility :			
Facility name:		Facility contact person:	
Phone:		Fax:	
Address: <i>(include city, state, zip)</i>			
Was the member evaluated by an in-network specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are the requested services available in the network? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Services Requested			
ICD10 Diagnosis code:		CPT Procedure code(s):	
<input type="checkbox"/> Initial Request <input type="checkbox"/> Extension Request <input type="checkbox"/> Non-urgent service <input type="checkbox"/> Clinically urgent service <input type="checkbox"/> Retroactive Service:			
<input type="checkbox"/> DOS not scheduled yet <input type="checkbox"/> DOS scheduled on: _____ <input type="checkbox"/> Retrospective DOS: _____			Number of visits:
Service location: <input type="checkbox"/> Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Home			

05/07/2019