P.O. Box 30377
Lansing, MI 48909-7877
Phone: 517.364.8560 Fax: 517.364.8409

Medical Prior Authorization and/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: *(include city, state, zip)*	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: *(include city, state, zip)*	
Was the member evaluated by an in-network specialist? ☐ Yes ☐ No	Are the requested services available in the network? ☐ Yes ☐ No

Services Requested	
ICD10 Diagnosis code:	CPT Procedure code(s):
☐ Initial Request ☐ Extension Request ☐ Non-urgent service ☐ Clinically urgent service ☐ Retroactive Service:	
☐ DOS not scheduled yet ☐ DOS scheduled on: ____________________ ☐ Retrospective DOS: ____________________	Number of visits:
Service location: ☐ Office ☐ Outpatient ☐ Inpatient ☐ Home	

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