perlman ++
medical group

Perlman Medical Group
Prior Authorization Request Form

***** Please Fax request to (866) 680-3587 *****

STATEMENT TO PROVIDER: This referral is for requested services only. Prior authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of a member's eligibility on the date of service, benefit limitations, and other applicable claim review standards.

MEMBER INFORMATION

Member Name: ____________________________ DOB: _________________ Phone #: ____________________

Member ID#: ____________________________ Health Plan: ___________________________________

Service Type: ☐ Routine ☐ Expedited/Urgent ☐ Routine – Part B Drug ☐ Urgent - Part B Drug

*Expedited/Urgent request designation is to be used only when treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function.

SERVICE INFORMATION

***Requesting* Provider Information**

Name: ____ NPI:____

Phone #:_______________________________________ Fax#:____

***Referral* Provider Information**

Name: ______________________________ Phone#: __________________ Facility: _______________________

Specialty: ____________________________ Fax#: __________________ Outpatient: ______________________

Phone #: ________________________________ Inpatient: ______________________

Address: ____

Number of Visits Requested: ______________________ DOS From: ___/___/____ to ___/___/____

<u>Please include pertinent past medical history Treatment, physical findings, and attach all relevant medical records and test results, etc.</u>

CPT CODE	Units:
CPT CODE	Units:
CPT CODE	Units:
CPT CODE	Units:
CPT CODE	Units:
ICD-10 CODE	
ICD-10 CODE	
ICD-10 CODE	
ICD-10 CODE	
ICD-10 CODE	
ICD-10 CODE	

Clinical Information: