

Prior Authorization Standard Request Form

(Do not use this form for DME, Home Health, Therapy, ECT,
Psychological Testing, or for any Inpatient Behavioral Health Services)

Request completed by: _____ Phone #: _____

Date of Request: _____

Total Number of Pages: _____

**Important Note: Standard prior authorization requests are processed within 14 calendar days of receipt.
For urgent prior authorization requests please call 1-800-624-3879 to ensure optimal processing time.**

Member Information

Member Name: _____ Member ID #: _____ DOB: _____
Other Insurance: Yes No If yes, please specify: _____ Phone #: _____

Ordering Physician Information

Physician Name: _____ TIN/NPI #: _____
Address: _____
Phone #: _____ Fax Number: _____
Contact Person: _____

Servicing Provider/Facility Information

Servicing Provider/Facility Name: _____ TIN/NPI #: _____
Address: _____ Phone #: _____ Fax #: _____

Diagnosis Code(s): _____

CPT Code(s): _____

Clinical Rationale for service request: _____

Patient History

Other Exams: _____

Significant Signs and Symptoms: _____

Duration of Symptoms: _____

Other Treatments Performed: _____

Please include supporting document which might include:

Physician Notes Other Lab Results Specialist Consult Notes Diagnostic Tests
Radiology Results Assessments Medication Lists

Important: To prevent delays in processing time, please provide completed documentation specific to this request. Failure to do so may impact the final determination for this authorization.

Authorization does not guarantee payment. All authorizations are subject to member eligibility on the date of service. If member is determined ineligible, the member may be responsible for these services. To ensure proper payment for services rendered, referral provider/facility must verify eligibility on the date of service. Verify benefit coverage in the benefit matrix located at

http://www.mercycareplan.com/mcp/members/covered_benefits.aspx