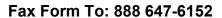
Medical Prior Authorization Form





Prior to completion, please review the list of specialty p	orior authorization fo	orms available on our <u>website</u> .
Date: Trovider Pre-servic	*Provider Pre-service Organization Determination	
*Check <u>only</u> if requesting a pre-service determination f	or a Part C Medicare	Advantage beneficiary
**See important message below if requesting services	f <mark>or a Medicaid Plan ı</mark>	<mark>member</mark>
Member:		
Last name:	First name:	
Priority Health ID #:	Date of birth:	
Reason for Referral:		
☐ Non-participating Priority Health Provider	Outpatient	Transplant Related
Elective Procedure	Inpatient	
Diagnosis:	Diagnosis code(s):	
Treatment/testing:	Procedure code(s):	
Date of visit/procedure:	Number of visits:	
Requested By:		
Provider name:	Phone:	Fax:
Provider tax ID (required):		
Address:	Contact name:	
Directed To:		
Provider name:	Facility:	
Provider tax ID (required):	Facility tax ID (required):	
Address:	Address:	
Provider phone: Fax:	Facility phone:_	Fax:
Contact name:	Contact name:	
For Inpatient Admissions:		
	UR phone:	UR fax:
Date of admission:		

To facilitate prompt and accurate processing, the information above must be complete and all supporting clinical documentation related to this request MUST be submitted with this form.

**In order to receive payment from any Medicaid program, new federal regulation requires that those providing services to a Medicaid beneficiary must enroll in CHAMPS (Community Health Automated Medicaid Processing System) to receive reimbursement. For more information, go to: https://milogintp.michigan.gov Contact the Medicaid Provider Helpline 1-800-292-2550