

Prior Authorization Request Form



Once completed, fax the form to: (910)-239-8293

All fields must be completed in order to process this request.

MEMBER INFORMATION

Name (Last, First, Middle Initial)

Member DOB (MM/DD/YYYY)

Member ID #

Member's Primary Care Physician

Gender: Male ☐ Female ☐

Request Priority (select one):

STANDARD ☐

EXPEDITED* ☐

***FOR EXPEDITED REQUESTS, CHECK BELOW TO THE MEMBER'S CONDITION MEETS ONE OR MORE OF THE FOLLOWING:**

- ☐ Seriously jeopardizes the life or health of the member
- ☐ Seriously jeopardizes the member's ability to attain, maintain or regain maximum function
- ☐ Condition subjects the member to uncontrolled pain

*Expedited requests require your physician's supporting statement.

SERVICING PROVIDER INFORMATION

Physician Name

Facility Name (if applicable)

Provider NPI#

Provider Phone #

Provider Fax #

CIRCLE REQUESTED SERVICE(S): Outpatient Part B Drug(s) Durable Medical Equipment (DME)

Description of Requested Service(s) Additional Info.	CPT/HCPCS	Start Date	End Date	Unit(s)
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