MEDICAL PRIOR AUTHORIZATION REQUEST FORM

NOTE: PLEASE ATTACH SUPPORTING CLINICAL INFORMATION WITH ALL REQUESTS
INCOMPLETE INFORMATION MAY DELAY PROCESSING OF REQUEST

Fax to: 877-443-9344 Email to: Claims@CareGuard.com Urgent/Same Day Requests call: 877-905-7322

.

Member Information

Member Name: _____ DOB: _____ Member ID #: _____

Submitted by / Sender Information

Submitted by: _____ Phone # (direct line): _____ Fax #: _____

Provider Information

Servicing Provider Name: _____ NPI #: _____

Phone #: _____ Fax #: _____

Servicing Facility Name:_____ NPI #: _____

Requested Services

Prior authorizations are only requested for procedures costing over $5,000. There are no expiration dates on prior authorizations.

Requested procedure description: _____

_____

Related CPT Codes: _____

Related Diagnosis Code(s):___

Home Health Care:

Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Home Health Aide ☐

Other (please specify): _____

Diagnosis Code(s): _____ CPT Code(s): _____ Is patient homebound? Yes ☐ No ☐

Additional Comments: _____

_____

_____

Determination: Approved ☐ Denied ☐ Partially Approved ☐

Reason for denial/partial approval:_____

_____

Additional information:_____

_____

Approved by: _____

Authorization is not a guarantee of payment. Payment is based upon eligibility of the member on the date of service, verification of the service as a covered benefit, and fund availability. Submission of cost or charge information does not guarantee payment at those rates. Authorization from any secondary insurance is highly recommended.