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: ______________________

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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: ______________________

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Determination: Approved ☐ Denied ☐ Partially Approved ☐

Reason for denial/partial approval: ______________________

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Additional information: ______________________

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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.