



Supplemental Prior Authorization Form

This page is optional and meant to be used when a request exceeds more than four (4) Procedure Codes.

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Member ID

Last Name, First

AUTHORIZATION REQUEST

*Additional Procedure Code

*Start Date OR Admission Date

*End Date

Total Units/Visits/Days

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

Additional Procedure Code

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Start Date OR Admission Date

End Date

Total Units/Visits/Days

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

Additional Procedure Code

Start Date OR Admission Date

End Date

Total Units/Visits/Days

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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