

Prior Auth Request Form

Request Date ____/____/____ Start of Care Date ____/____/____

Provider Name _____

Office Representative _____

Participating providers with access to 22 Health Provider Portal, Epic Link/PlanLink, are REQUIRED to submit Prior Auth requests through the portal along with the appropriate clinical information.

NOTE: AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.

22 Health Phone: 1-866-357-4082 | 22 Health Prior Auth Fax: 1-954-417-7104

Member Name _____

Date of Birth ____/____/____ Member ID # _____

Referred BY Provider:

Provider Name _____ NPI # _____

Provider Phone # _____ Provider Fax # _____

Provider Tax ID # _____

Referred TO Provider:

Provider Name _____ NPI # _____

Provider Phone # _____ Provider Fax # _____

Provider Tax ID # _____

☐ Standard Priority (Process within 15 calendar days)

☐ Expedited Priority (Process within 3 calendar days)
Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the member.

Reason for Request:

Attach pertinent medical records to assist in medical necessity review and timeliness of decision

Diagnosis & ICD-10 _____

Procedure & CPT _____

Comment _____

Place of Service ☐ 11 - Office ☐ 21 - IP Hospital ☐ 22 - OP Hospital ☐ 12 - Home

☐ 24 - Amb. Surgery Center ☐ Other, please specify: _____

Facility Name _____

Provider's Name _____ Date ____/____/____

Provider's Signature _____