



**Prior authorization supporting
documentation cover sheet**

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Fax:
1-855-268-2904
Phone:
1-888-556-7048

Requestor contact: _____

Phone: _____ Ext: _____

Fax: _____

IMPORTANT: Complete all fields on this form to ensure timely review.

Supporting documentation for existing prior authorization requests

Attach clinical information to support prior authorization request (e.g., plan of care, medical records, lab reports, letter of medical necessity, progress notes, etc.).

Case ID: _____

Patient name: _____ **DOB:** _____

Comments:

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

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