



Prior Authorization/Coverage Determination Form

Fax: 812-378-7054 Phone: 855-247-3233 Online: www.currenthealthsolutions.org

Section I - General Information

Review Type:
Standard
Expedite (currently inpatient or delay will be detrimental to patient's life/ health)
Clinical reason to Expedite:
Inpatient Outpatient Observation SNF IP Rehab
Initial or Pre-Service Request Extension/Renewal/Amendment (Previous auth #)

Section II - Enrollee Information

Name: Phone: DOB:
Enrollee ID: Group #

Section III - Provider Information

Requesting Provider or Facility Service Provider or Facility
Name: Name:
NPI: Group NPI: NPI: Group NPI:
Phone: Fax: Phone: Fax:
Address: Address:
Tax ID: Tax ID:

Section IV - Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)

Table with 5 columns: Planned Service or Procedure, Code, Start, End, Diagnosis (ICD Version 10)

Medication-MD signed Order Required:
MD Supplying and Billing OR Retail

Outpatient Therapy:
Physical Therapy Occupational Therapy Speech Therapy

DME-MD signed Order Required:
Rental \$ Per OR Purchase \$

Section VI - Clinical Documentation

Please attach clinical documentation to support this request. If this request is for medication, please list other medications that are tried and failed when applicable.

MD signed order required for DME, Medication, and Home Health Care

Contact Name and Phone Number/Fax regarding this request is:
Name: Phone: Fax: