



***Organization Determination/*Prior Authorization Form**

Forms should be faxed to 1-877-482-9749

Date / /

Member Information

Member Name _____ Member ID _____		
Member Address (Street, City, State, ZIP)		
Member Phone	Member Gender	Member DOB
	F/M	_ / _ / _

Physician Information

Treating Physician Name _____	
<input type="checkbox"/> Please check here if you are submitting this Organizational Determination/Prior Authorization Form on behalf of and with Member/Patient's knowledge and consent.	
Address (Street, City, State, ZIP)	
Telephone Number Office ()	Fax Number Office ()
Contact Name	Provider Number

Diagnosis and Medical Information

<u>Service Description</u>	<u>Procedure Code</u>	<u>Diagnosis Code</u>	<u>Place of service</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician Signature: _____	Date: _____
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*Prior Authorization is required on Medi-Pak HMO only for inpatient and skilled nursing facilities.

*Organization Determination requests are to determine if a specific service is covered.