

# Authorization Request Form

Fax to 614-259-0293

Date: \_\_\_\_\_

**Request Type**       Routine       Urgent       Retroactive

**Requesting Provider**

Requesting Provider Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Patient Information**

Patient ID: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_  
 Patient Name: \_\_\_\_\_ Sex: \_\_\_\_ Male \_\_\_\_ Female  
 Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Best Contact #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
 Carrier Name: \_\_\_\_\_  
 PCP ID#: \_\_\_\_\_ PCP Effective Date: \_\_/\_\_/\_\_\_\_

**Referred To Provider**

Service Location:  Home  Office  Outpatient Hospital  Ambulatory Surgery  Inpatient  Other  
 Specialty: \_\_\_\_\_  
 Provider ID: \_\_\_\_\_ Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Requested Treatment**

Diagnosis:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Procedures:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Clinical Comments:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_