



Medical Prior Approval or Out of Network Request Form

Save time and use PHP's EZ auth portal to submit authorizations, click here: HealthTrio Connect - PHP

Instructions: Please fill out this form completely. Documentation that must be submitted with the request includes:

✓ Clinical documentation that supports the need for the service(s)

 \checkmark Any other pertinent information for the review of this request.

Fax this form and relevant chart notes to 517.364.8409 Monday - Friday, 8 a.m. to 5 p.m. EST

Patient Information	Referring Provider Information
Today's date:	Referring Provider name:
Member name:	Office phone: Fax:
Member's PHP ID#:	Office contact:
Date of birth:	Patient's Primary Physician:
Provider/Facility Information (if applicable)	
Treating Provider name:	Specialty:
Phone #:	NPI#:
Fax #:	TIN #:
Address: (include city, state, zip)	Office contact person:
If the request is a procedure , and will be performed at a faci	lity:
Facility name:	Facility contact person:
Phone:	NPI#:
Fax:	TIN #:
Address: (include city, state, zip)	
Was the member evaluated by an in-network specialist?	Are the requested services available in the network?
Yes No	Yes No
Services Requested	
ICD10 Diagnosis code(s):	CPT/HCPCS codes:
	# of units/visits:
Initial Request Extension Request Non-Urgent Service Clinically Urgent Service Retroactive Service:	
DOS not scheduled yet DOS scheduled on:	Retrospective DOS:
Service location: Office Outpatient Hospital	Inpatient Hospital Home Other

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