Prior Authorization Request Form

Nascentia Health

TOMORROW'S HEALTHCARE TODAY

Please submit your request via fax or phone:

Referrals and Authorization Department

Phone: 1-888-477-4663
Fax: 1-315-870-7788

With your submitted form, please attach supporting clinical documentation

- Incomplete forms and requests without clinical information will delay processing
- A Prior Authorization is not a guarantee of payment; Payment is subject to member eligibility and benefits at the time of service
- Please allow 14 days for processing

☐ Provider Pre-Service Organization Determination (check only if requesting pre-service determination for a Part C Medicare Advantage beneficiary)

ORDERING PROVIDER INFORMATION

First Name:	Last Name:	Contact Phone #:	Contact Fax #:

Contact Person at this office:	☐ Ordering provider is PCP PCP's Clinic Name:	☐ Ordering provider is Specialist Speciality:

PATIENT INFORMATION

First Name:	Last Name:	MI:	Date of Birth:

Member ID:	ICD 10 Codes:

SERVICE PROVIDED BY

First Name:	Last Name:	Address:

☐ Participating ☐ Non-Participating	Tax ID: NPI:	Specialty:	Contact Phone #:	Contact Fax #:

Facility Name:	Address:

☐ Participating ☐ Non-Participating	Tax ID: NPI:	Specialty:	Contact Phone #:	Contact Fax #:

☐ Inpatient ☐ Outpatient Please indicate **CLINICAL** urgency of request: ☐ Routine ☐ Urgent

Diagnosis: Primary: Code (_____) Description: _____ Secondary: Code (_____) Description: _____	Date of Service:

Services being requested: CPT /HCPCS #1 _____ Description: _____ CPT /HCPCS #2 _____ Description: _____ CPT /HCPCS #3 _____ Description: _____	☐ New request ☐ Extension Request* # Visits: _____ Duration: _____ *Last Date of service if an extension _____