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 7 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 ClinicName:	☐ Ordering provider is Specialist Specialty:	

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: GROUP NPI:	Specialty:	Contact Phone #:	Contact Fax #:

☐ Authorization For Provider ☐ Authorization for Facility ☐ Authorization for Both

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 _____