QUALITY CARE PARTNERS

☐ *URGENT*

Please complete Prior Authorization Form and fax to: 740-455-8817
Eligibility and/or Benefit verification can only be provided by the claims payor.

For QCP Use Only:

Precert Initiated:_____

By: _____

Please fax to: Case Management at 740-455-8817

PATIENT LAST NAME:	PATIENT FIRST NAME:	MI	PAYOR:

SUBSCRIBER SS#:	DATE OF BIRTH:	PHONE NUMBER:	EMPLOYER:

ADDRESS	CITY	STATE	ZIP

REFERRING PHYSICIAN NAME & ADDRESS: TIN # AND NPI #	CONTACT PERSON:	PHONE NUMBER:	FAX NUMBER:

DIAGNOSIS:	ICD-9 CODE(S):

TREATMENT ATTEMPTED / FAILED TO DATE / REASON FOR REQUESTING:

PROCEDURE/HOSPITAL STAY ELECTIVE HOSPITAL ADMISSION, PROCEDURE OR OUTPATIENT SERVICE	PHYSICIAN REFERRAL
PHYSICIAN NAME AND ADDRESS: TIN # AND NPI #	PHYSICIAN NAME AND ADDRESS: TIN # AND NPI #
PROCEDURE TO BE PERFORMED & CPT CODE:	SPECIFIC SERVICE REQUESTED:
REQUESTED ADMISSION DATE:	TYPE OF REFERRAL: ☐ CONSULT & DIAGNOSIS ONLY (CD) ☐ CONSULT & TREAT (CT)
ANTICIPATED LENGTH OF STAY:	EXPECTED DURATION OF TREATMENT: _____ # OF VISITS APPOINTMENT DATE _____
FACILITY NAME/ ADDRESS: TIN #	ANTICIPATED START AND END DATES FOR TREATMENT: START: _____ END _____

REASON CODES: **1 - Documentation Does Not Support the Need for Treatment Requested**
2 – Provider Not Participating **3 - Service can be Provided by In Panel Provider**

Disclaimer Statement:
This determination verifies participation in the review process and is based upon the medical information provided. This determination does not guarantee payment of benefits. Payment of benefits are determined by medical necessity, subsequent review of medical information or records, eligibility, contract limitations of the plan and provider network participation at the time the service is rendered.