QCP
QUALITY CARE PARTNERS

ANTIDOTE Prior Authorization Form

Date Submitted	Submitted by	Phone	Fax

Employer	Subscriber SSN/ID

Patient Last Name	Patient First Name	M. Initial	Date of Birth	Gender
				Male

Address	City	State	Zip

Referring From Provider			Referring To Provider		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	
Tax ID	NPI		TaxID	NPI	

Initiated By	Receipt Method	Referral Service Type
Provider	Provider Fax/Email	

Newborn	Pre-Auth	Services Desired	Place of Service	Readmission
☐				☐

ICD Codes	CPT Codes

Procedure(s)	Specifics

Additional Notes

Please send any additional clinical with this form