Medical Pre-Authorization Form

Please complete all sections to prevent delays in approval. Attach clinical notes and supporting documentation.

I. Patient Information			
Full Name		**Date of Birth**	
Member ID / Policy #		**Phone Number**	
Address			

II. Provider Information			
Referring Physician Name		**NPI #**	
Facility / Practice Name		**Phone / Fax**	
Address			

III. Requested Service / Procedure Information			
Service/Procedure Name		**CPT / HCPCS Code**	
Date of Service		**Diagnosis (ICD-10)**	
Frequency/Units		**Place of Service**	
Medical Necessity / Justification:			

IV. Insurance Details			
Insurance Company		**Plan Type**	
Authorization # (if previously obtained)		**Case Manager (if applicable)**	

V. Attachments

- Clinical notes supporting medical necessity
- Relevant test results/Lab reports
- Other supporting documentation

VI. Provider Certification & Signature

☐ I certify that the above information is accurate and that the requested service is medically necessary.

Provider Signature: _____

Date: _____

This is a sample medical pre-authorization form template. Please verify insurer requirements as forms may differ.