Prior Authorization Fax Request Form:
800-766-2917

This FAX form has been developed to streamline the Prior Auth request process, and to give you a response as quickly as possible. Please complete all fields on the form, and refer to the listing of services that require authorization; you only need to request authorization for services on that list. The list can be found at www.americhoice.com. Please select the appropriate health plan and refer to provider materials.

Date: _____ Contact Person_____

Telephone #: _____ Fax #: _____

Requesting Provider: _____ Telephone #: _____

☐ Initial request ☐ Urgent ☐ Routine

☐ Request for an extension ☐ Urgent ☐ Routine

Urgent is defined as "significant impact to health of the member if not completed within 72 hours"

Member Information:

Member Name: _____Member ID/JD#_____ Date of Birth: _____

Patient Name: _____Member ID/JD#_____ Date of Birth: _____

Is request related to MVA or work-related injury? Does member have other insurance?

☐ Yes ☐ No ☐ Yes ☐ No Medicare ☐ Part A ☐ Part B

Other insurance name and policy #___ _____

Servicing Provider Information:

Date of Service: _____ Provider ID:_____

Physician or Servicing Provider: _____ Phone #: _____

Address: _____ Fax #: _____

Facility: _____ PAR or Non-PAR (please circle one)

If Non-par will provider accept Medicaid/Medicare default rate - ☐ Yes ☐ No

Type of Service:

☐ DME – Purchase	☐ Cosmetic or Reconstructive	☐ Home Health/Hospice Services
☐ DME – Rental	Surgery	☐ Skilled Nursing Facility
☐ Prosthetic / Orthotics	☐ PT / OT / ST	☐ Hysterectomy
☐ Inpatient Elective Surgery	☐ MRI, MRA or PET Scan	☐ Out Of Network (please explain)
☐ Transplantation Evaluation	☐ Gastric Bypass Eval/Surgery	☐ Other _____

Clinical Information:

Diagnoses:_____ICD-9 Codes: _____

CPT/HCPCS Codes: _____

Procedures: _____

Number of visits:_____ Duration:_____ Frequency: _____

Number of previous visits: _____ Service name/code for previous visits: _____

NOTE: In order to process your request completed and timely, Please submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. **FAILURE TO PROVIDE SUFFICIENT CLINICAL INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST.**