REQUEST FOR PRIOR AUTHORIZATION  Date of Request* *Required fields	superior healthpla
Urgent Request - By checking this box, I certify that this is an urgent request m Please Note: Urgent is defined as a health condition, including an urgent behave enough to require medical treatment evaluation or treatment within 24 hours to	edically necessary treatment, which must be treated within 24 hours.
Member Information	, provide decide action of the months. Community making
First Name	Member ID*
Last Name	Date of Birth*
Servicing Provider Information	
NPI* TPI*	Contact Number*
NPI* TPI*  Tax ID*  Last Name, First Initial or Facility Name	Fax Number*
Last Name, First Initial or Facility Name	
Contact Name / Requestor	
Referring Provider Information (eg. PCP or Specialist)	ck box if same as above.
NPI* TPI*	
NPI* TPI* Tax ID*	Fax Number*
Last Name, First Initial or Facility Name	
Contact Name / Requestor	
Requested Service	
Type of Service	Place of Service*
DME Rental* DME Purchase* DME Incontinence Supplemental DME Rental* DME Purchase* DME Incontinence Supplemental DME Incontine	Outpatient Hospital / ASC Gen  Yes
	ck box to indicate clinicals or plan of care.
Procedure Codes	Service Description
Procedure code / CPT, HCPCS* modifier Procedure code / CPT, HCPCS modifier Procedure code / CPT, HCPCS modifier Diagnosis	Start Date*
Referring Diagnosis code*	End Date*
Referring Diagnosis code	Units / Visits* X DD Wk MM
Contact Information	
otline	uesting Physician vices be approved before the service is rendered. Please refer to SuperiorHealthPlan.cor ull listing of authorized procedures and services. Note that an authorization is not a t and is subject to utilization management review, benefits and eligibility.

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**Dates Authorized** 

Units

**Authorization Number**