

# Prior Authorization Request Form



A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient.

Network exception request  
One-time agreement request  
Medical coverage for dental

- PacificSource responds to prior authorization requests within two (2) business days if received before 3:00 p.m.
- Requests received after 3:00 p.m. are processed the next work day.
- Incomplete information will delay the prior authorization process.
- Please include pertinent chart notes to expedite this request.
- In-network providers may submit online through InTouch, at [PacificSource.com](http://PacificSource.com).

## Requesting provider contact information

Contact person \_\_\_\_\_ Office name \_\_\_\_\_ Date \_\_\_\_\_  
Phone \_\_\_\_\_ Extension \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

## Patient information

Last name \_\_\_\_\_ First name \_\_\_\_\_  
DOB \_\_\_\_\_ Member number \_\_\_\_\_

## Procedure information

CPT/HCPCS/CDT and description \_\_\_\_\_  
CPT/HCPCS/CDT and description \_\_\_\_\_  
CPT/HCPCS/CDT and description \_\_\_\_\_  
CPT/HCPCS/CDT and description \_\_\_\_\_  
CPT/HCPCS/CDT and description \_\_\_\_\_  
CPT/HCPCS/CDT and description \_\_\_\_\_

Diagnosis code(s) and description(s) \_\_\_\_\_

Retrospective review?    Yes    No    Dates of service \_\_\_\_\_    To be scheduled  
    Inpatient    Residential    Estimated length of stay (number of days) \_\_\_\_\_  
    Outpatient    Office    Home    Durable medical equipment:    Rental    Purchase    Cost \$ \_\_\_\_\_

## Provider information

Ordering provider or surgeon \_\_\_\_\_ NPI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Tax ID \_\_\_\_\_  
Place of service, vendor, or facility \_\_\_\_\_ NPI \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Tax ID \_\_\_\_\_

### Health Services Department