Prominence® Health Plan

PRIOR AUTHORIZATION REQUEST FORM

In order to process the request, please complete the entire form all include all clinical records.
Fax the form to one of the following numbers based on member enrollment:

MEDICARE 813-513-7304 | COMMERCIAL FULLY INSURED 775-770-9122 | ASO SELF-FUNDED 775-770-9037

FORM TYPE:
- ☐ Standard - Medicare 14-day turnaround; Part B Drug 72-hour turnaround; Commercial 15-day turnaround
- ☐ Retrospective - 30-day turnaround
- ☐ Concurrent Review - 24-hour turnaround
- ☐ Hospital Discharge Assistance
- ☐ Medicare Expedited Part B Drugs - 24-hour turnaround
- ☐ Medicare Standard Part B Drugs - 72-hour turnaround

☐ **URGENT/EXPEDITED - 72-hour turnaround for Medicare/Commercial / 24-hour turnaround for Part B Drugs**
Check here to attest that the member's condition meets one of the following:
- ☐ Seriously jeopardize the life or health of the member
- ☐ Seriously jeopardize the member's ability to attain, maintain or regain maximum function

NOTE! An Urgent/Expedited request may be processed as standard if it does not meet at least one of the criteria listed above.

Member Name (Last, First, Middle Initial)		Member DOB (MM/DD/YY)
Member ID #	Plan/Group #	Primary Care Provider

ORDERING/REQUESTING PROVIDER INFORMATION:

Provider Name	Contact at Provider Office	Requesting Facility
Provider NPI #	Provider Phone #	Provider Fax #

SERVICING PROVIDER/FACILITY: ☐ Inpatient ☐ Outpatient ☐ Office ☐ DME/HH

Provider Name	Type of Provider/Specialty	Facility Name
Provider NPI #	Provider Phone #	Provider Fax #
Servicing Provider Contact	Provider Specialty/Facility Type	

ICD 10 Codes:			

All column fields if applicable, MUST be completed. DO NOT LEAVE BLANK.

Description of Requested Service or Medication Name	CPT/HCPCS/J CODES	Start Date	End Date	Visits/Units

Medication Requests (if applicable)	Dose (mg, etc.):	Frequency (every 4 weeks, etc):	Continuation Request (y/n):

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.