

**EPO PRIOR AUTHORIZATION REQUEST FORM**

**If you have access to EPIC, please complete this form through John Muir Health’s EPIC platform. This form is for providers submitting an EPO prior authorization request *only* if they cannot access EPIC. To submit a PPO prior authorization request, please visit** [**https://jmhprecert.lucenthealth.com/**](https://jmhprecert.lucenthealth.com/)**.**

**Complete the following information: DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring MD Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION REQUEST**

Complete this section when requesting a service that requires authorization and submit the form to the Care Management Department via fax.

 Phone: (***877) 214-2106***  Fax: ***(615) 461-5354***

**Routine Request [ ]**

Determination will be made within 5 working days of receipt of all clinical information

**The following is to be checked ONLY when the time frame of the standard decision-making process could seriously jeopardize the life or health of the member or could jeopardize the member’s ability to regain maximum functionality**

**MEDICALLY Urgent Request [ ]**

|  |  |
| --- | --- |
| Diagnosis (Narrative): | ICD 10 (list all and include 4th & 5th digit when indicated) |
| Findings/Treatment to date **(please attach all pertinent information)** ***NOTE: SUBMISSION OF DETAILED CLINICAL INFORMATION WILL ENABLE REQUESTS TO BE PROCESSED IN A TIMELY MANNER***  |
| Requested Service (If OON or non-contracting provider is being requested, please list reason service cannot be provided in network)**If this is a patient request, please check this box [ ]**  | CPT (List all) |
| Requested facility/provider name: | Check Appropriate box:[ ] in-patient [ ] out-patient [ ] Assist. Surgeon [ ] other |
| Requesting Provider Signature:  | Phone #:Fax #:  |