Prior Authorization Fax Form
Complete this Form and Fax to **1- 877-650-6943**
NOTE: Incomplete forms may delay processing and will require Magnolia Health Plan to request additional information.
Effective: 8/1/2012

○ **STANDARD REQUEST**- Determination provided within 2 business days of Magnolia Health Plan's receipt of all required information.

○ **URGENT REQUEST** – By selecting this choice, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another condition (usually not life threatening) which must be treated within 24 hours.

ALL URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN IN ORDER TO BE PROCESSED AS URGENT

_____
Signature of Requesting Physician

Request Date: _____
Requesting Provider Name: _____ Requesting Provider Phone Number: _____
Requesting Provider Fax Number: _____ Contact Name: _____
Tax ID# (TIN): NPI#:

PATIENT INFORMATION

Name (Last, First, Middle Initial):	**Date of Birth:**
Member Medicaid ID#	

Other Insurance? If yes, Name of Carrier:_____ **Carrier Contact Number:**_____
Policy Number: _____ **Group Number:**_____

MUST BE COMPLETED

Referring To Specialist and /or Facility: ☐ Participating ☐ Non-Participating

Facility where procedure(s) will be performed:		
Tax ID # (TIN):	NPI#:	
Address/Location:		
City:	Zip:	Facility Type:
Telephone Number:	Fax Number:	

Purpose of Referral:

☐ Consult Only	☐ Diagnostic / Radiology	☐ Therapy ***See Therapy Form**
☐ Consult w/Treatment	☐ Outpatient Surgery	☐ Other (please specify)
☐ Follow-up Visit	☐ Inpatient Admission	_____
☐ Consult & Follow-up Visit		

SEND COPIES OF APPROPRIATE SUPPORTING CLINICAL INFORMATION FOR ALL CASES WITH THIS FORM

Diagnosis/ICD Code(s) to be billed:

Procedure/CPT Code(s) to be billed:
☐ Initial Request
☐ Subsequent Request

Number of treatments/visits:	Requested Start Date:_____ Requested End Date:_____

If the service is denied, the requesting physician may request a Peer-to-Peer discussion with the Magnolia Health Plan Chief Medical Director. A denial letter, including appeal rights, will be mailed to the requesting provider.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Magnolia Health Plan Benefit and medically necessary with prior authorization in accordance with Magnolia Policies and Procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient of this facsimile transmission, any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately at 1- 866-912-6285 and destroy this document.