Prior Authorization Request Form

MOUNT CARMEL Health Plan
A Member of Trinity Health
MediGold

Fax Requests to **1-833-263-4869**

Patient Name:_____

Member ID:_____

Date of Birth:_____ /_____ /_____

Phone Number (____)_____

☐ **Expedited**

Read Definition below prior to checking box. Check expedited **ONLY** if it meets the definition of expedited request per CMS Guideline 50 - Expedited Organization Determination: Enrollee/ Physician believes that waiting for a decision under the standard time frame (14 days) could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

Please select service(s) for which you are requesting prior authorization.

- ☐ Home Health Care
- ☐ BRAC gene testing
- ☐ Integrated Oncology/Radiation Therapy Power
- ☐ Operated Vehicles (CMN required)
- ☐ Durable Medical Equipment (DME)
- ☐ Inpatient Rehabilitation/Long Term Acute Care Admit Part B Therapy
- ☐ Part B Drugs/Chemotherapy Drugs
- ☐ Transplant Evaluation or Transplant
- ☐ Hyperbaric Oxygen

Other:_____

☐ Elective Procedure: please select expected bed type below

☐ Inpatient ☐ Observation ☐ Outpatient

Requesting Provider's Name:_____

Provider's Phone: (____)_____Provider's Fax: (____)_____

Name of Person Completing Request:_____Contact Phone:(____)_____

Servicing Facility (if applicable):_____

Facility NPI:_____Facility TIN:_____

Servicing Provider:_____

Provider NPI:_____Provider TIN:_____

Provider's Phone: (____)_____Provider's Fax: (____)_____

Start Date: Frequency:_____

Applicable Diagnoses & ICD-10 Codes:_____

Service Description and Code(s):_____

Medical Rationale for Request:_____

OUT-OF-NETWORK CARE for HMO Members (does not apply for PPO members): Out-of-network care is only considered when services are not accessible in-network.