Mercy Care Plan (MCP)/Mercy Healthcare Group (MHG)

Prior Authorization Request Form

(Excluding DME/Medical Supplies)

Fax: (602) 431-7555
1-800-217-9345

Phone: (602) 263-3000
1-800-624-3879

COMPLETION of this form will expedite authorization

Return authorization to requesting provider fax number at:

(_____)_____

Date of Request:

Member Information

Member Name: Member ID Number: DOB:

Address: Confirmed ☐ Yes ☐ No

Phone Number: Medicare ☐ Yes ☐ No Other Insurance ☐ Primary Language Spoken/Read /

Requesting Physician Information

Name of Requesting Physician: Name of Person Completing Form:

Clinic/ Office Address: Phone Number:

Out-Patient Service/Specialist Request

Requested Provider Name: **TIN/NPI #:**

Address:

Phone Number: Date of Service:

☐ Evaluation/Consultation only ☐ Evaluation and Treatment ☐ Follow-Up Visit(s) _____ ☐ Total OB Care

☐ Home Health Care _____RN _____PT _____OT _____ST Frequency: _____ Duration: _____

☐ OutPatient Therapy _____PT _____OT _____ST Frequency: _____ Duration: _____

☐ **Diagnosis:** **ICD-9:** ☐ **CPT Code(s):**

Surgical/Hospital Request

Referral Physician:

Address: Phone #: Fax #:

Surgical/Diagnostic Procedure: **CPT Code (s):**

Surgeon/Asst. Surgeon:

Facility/Hospital: Date of Service:

☐ InPatient Services ☐ OutPatient Services ☐ 23 Hour Short Stay/Observation

Diagnosis: **ICD-9:**

Patient Symptoms:

Conservative Treatment Tried:

****Include or attach any documentation to support medical necessity of this request.****

Authorization is subject to eligibility on date of service. If member is determined to be ineligible on date of service, the member may be responsible for these services.

To ensure proper payment for services rendered, referral provider/facility must verify eligibility on the date of service.