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Prior Authorization Request Form

Member Information

Patient Name:

Cardholder ID:

Group #:

Birth Date:

Address:

City, State, Zip:

Phone Number:

Primary and Secondary Medical Coverage:

Practitioner Information

Doctor's Name:

Office Contact:

Specialty:

Address:

City, State, Zip:

Phone Number:

Fax Number:

Medical Information

Please provide all requested information. Incomplete forms will be returned for additional information.

Medication Requested:

Dose/expected duration of treatment:

Diagnosis/reason for request:

Pertinent labs or diagnostic test results:

Other medications used to treat condition and dates used:

Outcomes:

Doctor's Signature: **Date:**

For EHIM Use Only

Prior Authorization Reference #:

Date and Time Received:

Pharmacy Name: **Pharmacy Phone:**

Approved/Denied (circle one) by: **Approval Expiration Date:**

Date/time returned to provider:

Comments:

***If the physician wishes to request continuation of the Prior Authorization for a period of time that exceeds the approved expiration date, the physician will need to supply clinical information to support the need. Authorizations are not given for over one year. If required, submit an extension request prior to the end of the authorization period.**

If you have any questions contact EHIM's Department of Clinical Services at (800**)** 311-3446 **or fax us at (**313**)** 447-2052**.**

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