PRIOR AUTHORIZATION FORM

Submission of this form will serve as notice to PreferredOne of an episode of care. In addition to demographics, clinical documentation must be provided by email or fax to perform the medical / therapeutic necessity review and final completion of the certification process. **Clinical documentation supporting the medical necessity of the requested service, procedure, device, or test is required.** This includes current vital signs, medications, lab and test results, activity level, therapy notes, consult notes, plan of care, discharge planning (as applicable to the request).

Please email this form and clinical documentation to Intake@Preferredone.com or fax to (763) 847-4014.

MEMBER / SUBSCRIBER INFORMATION			
Patient Name	**PreferredOne ID #**	**DOB**	
Address			
City		**State**	**Zip Code**
Phone	**Email Address**		

ORDERING/TREATING PHYSICIAN/PROVIDER			
Requester Contact Name	**Phone**	**Fax**	
Ordering Provider Name (First & Last)		**NPI #**	
Clinic Name		**NPI #**	
Address			
City		**State**	**Zip Code**
Phone	**Fax**	**Email**	
Servicing Provider (Hospital/Clinic/Vendor) Name		**NPI #**	
Address			
City		**State**	**Zip Code**
Phone	**Fax**	**Email**	

PRIOR AUTHORIZATION FORM

PreferredOne®

Patient Name	
PreferredOne ID #	

Choose one:			
Inpatient	☐	**Anticipated Inpatient Admit Date (if applicable)**	
Outpatient	☐		

Diagnosis Code(s)
Requested Service/Procedure/Device/Test Procedure Code(s)
Acute symptoms/history/pertinent tests and results
Current TX plan

FOR REQUESTS FOR OUTPATIENT PHYSICAL, OCCUPATIONAL, AND/OR SPEECH THERAPY	
Select the type of therapy the patient is receiving:	
Habilitative	☐
Rehabilitative	☐