

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



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