MAGNACARE℠

Provider Prior Authorization Request Form

Approved prior authorization payment is contingent upon the eligibility of the member at the time of service. Authorizations are not a guarantee of payment, but are based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and/or qualifications and will be determined when the claim is received for processing.

PLEASE ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

Phone: 888-362-4624
Inpatient Fax: 516-723-7339
Outpatient Fax: 516-723-7306

☐ **ROUTINE*** ☐ **URGENT*** ☐ **TRANSPLANT***

By checking the URGENT box, the treating physician attests that a routine review time frame may seriously jeopardize the life or health of the member or the members' ability to retain maximum function.

☐ **Check here if this request is related to Transition of Care or Continuity of Care.**

MEMBER INFORMATION

Request Date _____ ID #* _____

Last Name* _____ First Name* _____

Date of Birth* _____ Phone # _____

Street Address _____ City _____ State _____ ZIP _____

☐ **Inpatient*** ☐ **Outpatient***

PLACE OF SERVICE: ☐ Office ☐ Home ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ ASC ☐ SNF
☐ IP Rehab ☐ Infusion Center ☐ Free Standing Radiology Facility ☐ Residential BH Treatment Facility ☐ LTAC

ORDERING/SERVICING PROVIDER INFORMATION:

First Name* _____ Last Name* _____

Tax ID* _____ NPI* _____ Phone #* _____ Fax #* _____

Street Address* _____ City* _____ State* _____ ZIP* _____

ORDERING/SERVICING PROVIDER INFORMATION:

First Name* _____ Last Name* _____

Tax ID* _____ NPI* _____ Phone #* _____ Fax #* _____

Street Address* _____ City* _____ State* _____ ZIP* _____

DX Code (1) _____ DX Code (2) _____ DX Code (3) _____

Additional Information: _____

Date(s) of Service:* **Start Date(mm/dd/yyyy)** _____ **End Date(mm/dd/yyyy)** _____

CPT/HCPCS			
Qty*	**CPT/HCPCS***	**Description of Service**	**U&C Charge**

Update to Current Auth # _____ # of Visits _____ Requested Extension Date _____

Work/Auto/Other Insurance _____

Our Mailing Address:
MagnaCare
c/o Utilization Management Department
1600 Stewart Avenue, Suite 700
Westbury, NY 11590

*Indicates Required Field