Prime Healthcare

Self-funded Employee Medical Plan

Pre-Authorization *–The Plan Sponsor requires pre-service review for all services with exception of: PCP visits, diagnostic testing performed at a Prime Facility, Annual Well Care, Urgent Care and Emergency Room visits. PCP should initiate requests however Specialists should submit requests for further care after initial visit.*
Note: *Without filling out the fields that are marked with asterisk (*), the decision for the requested Authorization will be delayed exceeded the expected turnaround time.*

***Patient Name**	**Hospital of Employment** *(Subscriber)*
***Home Address**	***Phone**
***Date of Birth**	***Member ID Number**
***Referring Physician & Phone**	**Primary Care Physician** & Phone
***Referred to**	
***Referral place of service, phone/address**	

Expected Date of Service *(valid for 90 days from authorization)* Date: ____

***ICD-10 Code** ____

***Diagnosis**

***CPT Code & QTY**____

***Description of Service & QTY**____

***Inpatient? Yes No** **RetroActive Request? Yes No**

Referring physician's notes **Return Fax #** ____

____

____

____

****Please include recent labs, pertinent imaging reports, problem list, allergies and relevant clinical notes****

X____

(Referring Physician Signature) ***(Date)***

Prime UR Department use only
☐ **Approved** ☐ **Denied** ☐ **Pending** *(additional information required)*
UR Director's Notes
Referral Tracking Number *(valid as authorization number, if approved)*______________________________

PROVIDERS – Fax Referrals and any supporting documentation to:
Prime Healthcare Utilization Review Department
Primary Fax: 1-909-235-4414 Alternate Fax1: 1-909-235-4404 Alternate Fax2: 1-909-235-4427
Referral Questions: call toll free 1-877-234-5227
Member Eligibility and Benefit Summary: call toll free 1-888-773-7218

Mandatory Field