Partners Health Plan

PHP CARE COMPLETE FIDA-IDD PLAN's Prior Authorization Request Form

Participant Name: _____Participant ID #: 450000_ _ _ _ _ _ _ (fill in last 7 digits)
Sex: _____ DOB: _____ Phone Number: (___) _____
Address: _____
County of Residence: _____

Participant Representative: _____ Phone Number: (___) _____
Address: _____
Participant PHP Care Manager: _____ Phone: (_____) _____

Requesting Provider Name: _____ NPI: _____
Address: _____
Phone Number: (___) _____Extension: _____

Servicing Providing Name (if different) : _____ NPI: _____
Address: _____
Phone Number: (___) _____ Extension: _____

Contact Name (person completing form): _____
Phone Number: (___) _____ Extension: _____

Check One: ___Inpatient ___Outpatient

Retrospective Request: ___Yes ___ If Yes, Date Service Provided: _____
Reason for failure to prior authorize: _____

Procedure or DME Being Requested: _____ CPT: _____

Pertinent Diagnosis: _____
Pertinent Diagnosis Code (s):
_____

Description of Symptoms:
_____
_____
Prior Treatment Provided (i.e., PT, NSAIDS):
_____
_____
Related Labs/Diagnostic Studies Results (i.e., X-Rays, Ultrasound, Labs):
_____
_____
_____

Please fax completed form, along with clinical information, to: 855-769-2509
For questions, please call 855-769-2508