PHP CARE COMPLETE FIDA-IDD PLAN
Prior Authorization Request Form

PHP™ PARTNERS HEALTH PLAN

Patient Information

Name (First, MI, Last):	DOB:	Member ID Number: Fill in last 7 digits 450000_ _ _ _ _ _ _
Address:		
Guardians Name:	Telephone Number:	

Date: Requesting Provider: ☐ In Network ☐ Out of Network	Phone Number	Fax Number:
Address:	Tax ID Number	NPI Number:
Treating Facility: ☐ In Network ☐ Out of Network	Phone Number:	Fax Number:
Address:	Tax ID Number:	NPI Number:

Provider Information

Contact Name (person completing this form):	Phone/Fax Number:	Represent: (check one) ☐ Provider ☐ Facility

Authorization Request Information

Check one: ☐ Inpatient ☐ Outpatient ☐ DME ☐ PT/OT/ST ☐ Maintenance in Home ☐ Maintenance outside home ☐ Restorative

Service Start Date _____/_____/_____ Service End Date ____/____/____

CPT/HCPCS CODE(S)	CPT/HCPCS CODE DESCRIPTION(S)	# VISITS/DAYS/ UNITS REQUESTED	ICD CODE(S)	DIAGNOSIS DESCRIPTION(S)

Send completed form and supplemental clinical to Health Smart fax number 855-769-2509

Incomplete forms or lack of supplemental clinicals can result in the delay of case set up and processing.