MAGNACARE℠

Provider Prior Authorization Request Form

PLEASE ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

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.

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

☐ **ROUTINE*** ☐ **URGENT***

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.

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 PROVIDER INFORMATION:

First Name* _____ Last Name* _____

Tax ID* _____ NPI* _____ Phone #* _____

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

SERVICING PROVIDER INFORMATION:

First Name* _____ Last Name* _____

Tax ID* _____ NPI* _____ Phone #* _____

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