PHP CARE COMPLETE FIDA-IDD PLAN
Prior Authorization Request Form

Patient Information
Name (First, MI, Last): [Blank]
DOB: [Blank]
Member ID Number: Fill in last 7 digits
450000_ _ _ _ _ _

Address: [Blank]

Guardians Name: [Blank]
Telephone Number: [Blank]

Date: [Blank]

Requesting Provider: [Blank] In Network [Blank] Out of Network
Phone Number: [Blank]
Fax Number: [Blank]

Address: [Blank]

Tax ID Number: [Blank]
NPI Number: [Blank]

Treating Facility: [Blank] In Network [Blank] Out of Network
Phone Number: [Blank]
Fax Number: [Blank]

Address: [Blank]

Tax ID Number: [Blank]
NPI Number: [Blank]

Provider Information
Contact Name (person completing this form): [Blank]
Phone/Fax Number: [Blank]

Represent: (check one)
[Blank] Provider [Blank] Facility

Authorization Request Information

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

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<tr>
<th>CPT/HCPCS CODE(S)</th>
<th>CPT/HCPCS CODE DESCRIPTION(S)</th>
<th># VISITS/DAYS/UNITS REQUESTED</th>
<th>ICD CODE(S)</th>
<th>DIAGNOSIS DESCRIPTION(S)</th>
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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.