



## Medical Prior Approval or Out of Network Request Form

Save time and use PHP's EZ auth portal to submit authorizations, click here: [HealthTrio Connect - PHP](#)

Instructions: Please fill out this form completely. Documentation that must be submitted with the request includes:

- ✓ Clinical documentation that supports the need for the service(s)
- ✓ Any other pertinent information for the review of this request.

**Fax this form and relevant chart notes to 517.364.8409 Monday - Friday, 8 a.m. to 5 p.m. EST**

Patient Information		Referring Provider Information			
Today's date:	Referring Provider name:				
Member name:	Office phone:	Fax:			
Member's PHP ID#:	Office contact:				
Date of birth:	Patient's Primary Physician:				
Provider/Facility Information (if applicable)					
Treating Provider name:	Specialty:				
Phone #: Fax #:	NPI #: TIN #:				
Address: <i>(include city, state, zip)</i>	Office contact person:				
If the request is a <b>procedure</b> , and will be performed at a <b>facility</b> :					
Facility name:	Facility contact person:				
Phone: Fax:	NPI #: TIN #:				
Address: <i>(include city, state, zip)</i>					
Was the member evaluated by an in-network specialist? <div style="text-align: center;">Yes      No</div>	Are the requested services available in the network? <div style="text-align: center;">Yes      No</div>				
Services Requested					
ICD10 Diagnosis code(s):	CPT/HCPCS codes:				
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<div style="display: flex; justify-content: space-between;"> <span>Initial Request</span> <span>Extension Request</span> <span>Non-Urgent Service</span> <span>Clinically Urgent Service</span> <span>Retroactive</span> </div>					
Service:					
DOS not scheduled yet		DOS scheduled on:			
		Retrospective DOS:			
<div style="display: flex; justify-content: space-between;"> <span>Service location:</span> <span>Office</span> <span>Outpatient Hospital</span> <span>Inpatient Hospital</span> <span>Home</span> <span>Other</span> </div>					