Triad HealthCare Network
Utilization Management

healthteam advantage

PHONE: 844-873-2905 FAX: 844-873-3163

PRIOR AUTHORIZATION REQUEST

☐ Prior to Service Authorization ☐ Services already initiated / retro authorization

Submitted by:(select one) PCP Office Specialist Office	Today's Date: / /
Person to contact for this Submission:	
Phone:	FAX:

Patient's Name:	DOB / /	Member ID:
Requesting Provider:		NPI:
Address:		Fax:
Where is service being provided?	Proposed Date of Service: / /	
❑ Outpatient ❑ Office ❑ Inpatient		❑ Ambulatory Surgery Center
Servicing Provider Name: (i.e. Facility or Provider Name, May be the same as Requesting Provider)		NPI:
Address:		Fax:

ICD 10 Code	Description	
CPT Code	**Description**	**Units/Quantity**
Please attach clinicals to support the medical necessity.		

This request will be treated as per the standard organization determination timeframes. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously **jeopardize the life or health of the member or the member's ability to regain maximum function:**

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Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to www.healthteamadvantage.com for specific codes requiring a prior authorization.