

PRIOR AUTHORIZATION FORM

FORWARD REFERRALS FROM CONTRACTED MD TO CONTRACTED MD (PRIOR AUTHORIZATION NOT NEEDED)

PSW contracted provider referring to another PSW contracted provider, no referral is required to be sent to PSW. Doctor to doctor only. FIND A LIST OF CONTRACTED PROVIDERS AT: www.pswipa.com/members/find-a-provider

FAX COMPLETED FORM TO 360.786.8751

MEMBER INFORMATION

MEMBER ID	MEMBER NAME	DOB	PHONE
OTHER INSURANCE (employee, MVA, workers comp, VA)			

ORDERING / REFERRING PROVIDER

PRIMARY CARE PHYSICIAN		REFERRING/ORDERING/PROVIDER	NPI NO. (IF DIFFERENT FROM PCP*)
PHONE	FAX	PHONE	FAX
OFFICE CONTACT		PHONE	

* PCP NOTIFIED OF THIS REFERRAL

REQUESTED PROVIDER / FACILITY PROVIDE DOCUMENTATION WITH THE REQUEST TO SUPPORT MEDICAL NECESSITY

REQUESTED PROVIDER / FACILITY	SPECIALTY	
NPI NO.	PHONE	FAX

TYPE OF REQUEST

ROUTINE
 RETRO
 EXPEDITED / URGENT (Request must include a physician's order stating that waiting for a decision under a standard timeframe could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.)

INPATIENT
 IPR
 OUT PATIENT
 LTACH
 SNF

APPOINTMENT PROCEDURE DATE _____

IF PROVIDER OR FACILITY IS NON-CONTRACTED, INDICATE REASON BELOW AND SUBMIT DOCUMENTATION WITH REQUEST

NOT AVAILABLE IN PSW NETWORK
 OTHER _____

REQUIRED: CPT / HCPCS CODE _____

ICD-10 CODES _____ MISC. AND / OR UNLISTED CODES - DESCRIPTION REQUIRED _____

NUMBER OF VISITS _____ START DATE _____ END DATE _____ FREQUENCY / UNITS _____

ADDITIONAL INFORMATION: _____