PSW
a population health company

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.

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

PHONE | FAX

REFERRING/ORDERING/PROVIDER | NPI NO. (IF DIFFERENT FROM PCP*)

PHONE | FAX

☐ * PCP NOTIFIED OF THIS REFERRAL

OFFICE CONTACT | PHONE

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 endager 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: ____________________