

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	MEMBED NAME	DOB	DHONE
MEMBER ID	MEMBER NAME	DOB	PHONE
OTHER INSURANCE (employee, MV	(A, workers comp, VA)		
	20110-0		
ORDERING / REFERRING PR	ROVIDER		
PRIMARY CARE PHYSICIAN		REFERRING/ORDERING/PROVIDER	NPI NO. (IF DIFFERENT FROM PCP*)
TRIMART CARE THIS ICIAN		NEI EIMMG/ONDERMOG/I NOVIDEN	MITTO: (II DITTERENT HOMT CITY)
		20005	
PHONE FAX		PHONE FA	x
		* PCP NOTIFIED OF THIS REFERR	AL
OFFICE CONTACT			PHONE
REQUESTED PROVIDER / F/	ACILITY PROVIDE DOCUMENTAT	TION WITH THE REQUEST TO SUPPO	ORT MEDICAL NECESSITY
DECULETED DROVIDED / FACULTY		CDECIALTY	
REQUESTED PROVIDER / FACILITY		SPECIALTY	
NPI NO.	PHONE		FAX
	PHONE		FAX
NPI NO. TYPE OF REQUEST	PHONE		FAX
TYPE OF REQUEST	DITED / URGENT (Request must include a	physician's order stating that waiting for a	a decision under a standard timeframe could
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TYPE OF REQUEST ROUTINE RETRO SEXPE INPATIENT PROCEDURE DATE IF PROVIDER OR FACILITY IS NON-COM	POITED / URGENT (Request must include a endager the member's repartient LTACH SNF	life, health, or ability to regain maximum	a decision under a standard timeframe could functionality or would cause serious pain.)
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