PSW a population health company

MultiCare Connected Care™

2026 Prior Authorization Request Form

Requests from contracted provider to contracted provider: Referrals not required to be sent to PSW. Refer to Prior Auth list to determine if requested services requires prior authorization. https://pswipa.com/prior-auth

Requests to non-contracted provider: All services require prior auth. Submit documentation for reason services are requested out of network.

MEMBER DETAILS

Member ID

Member Name

DOB

Member Phone

REQUESTING/ORDERING PROVIDER DETAILS

Ordering Provider Name

NPI

Provider/Office Phone

Provider Office/Fax

Provider/Office Contact

Contact Phone

REQUESTED DETAILS (PROVIDE DOCUMENTATION W/ REQUEST TO SUPPORT MEDICAL NECESSITY)

Facility/Provider Name (If IP Request, use Facility Name)

NPI

Facility/Provider Phone

Facility/Provider Fax

Place of Service/Request Type:

☐ Office ☐ IP Hospital ☐ OP Hospital ☐ ASC ☐ SNF ☐ IPR ☐ LTACH ☐ Psych Hospital ☐ Lab ☐ Imaging

☐ DME/Supplies/Orthotics ☐ Other: _____

Start Date

End Date (Leave blank if request is for a single DOS)

Diagnosis Codes (ICD-10)				

HCPCS Code / CPT Code	Name (Product/Service)	Total Requested Units	Frequency/Quantity	Dose (If applicable)

(Note: All reviews will be processed with generic equivalents for brand drugs whenever possible).

Patient Height (Circle, in or cm)

Patient Weight (Circle, lbs or kg)

☐ Routine Request ☐ Retro* *DOS prior to request date ☐ Expedited/Urgent* *Urgent indicates that waiting for a decision under a standard timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function; or cause serious pain.

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