



- Urgent
- Non-Urgent

PRIOR AUTHORIZATION FORM

Please provide information in the boxes below. **NOTE:** An authorization cannot be given unless all of the requested information is provided, including the proposed service date. Please fax the completed form, along with pertinent clinical information, to Absolute Total Care at **(866) 912-3606**.

Patient Name: _____

Absolute Total Care ID Number: _____

Patient Date of Birth: _____

Guardian/Parent Name: _____

Referring/PCP Physician Name: _____

Absolute Total Care Provider ID: _____

Phone: _____

Contact: _____

Fax: _____

Today's Date: _____

Diagnosis: _____ ICD-9 Code(s): _____

Refer to Provider/Procedure/Service: _____

NDC Code/CPT Code(s): _____

of Visits/Procedure and/or Service Date: _____ (MANDATORY)

Facility: _____

Please Circle One: Inpatient Outpatient Observation Medication Home Health SNF

ABSOLUTE TOTAL CARE USE ONLY

Authorization Number: _____ **Date:** _____

Approved ___ Disapproved ___ **A denial letter will also be issued if service request is denied.**

Number of Days Approved (inpatient only) _____

Reviewer Initials _____

A Determination Of Medical Necessity Is Not A Guarantee Of Payment Or Benefits.

Payment Is Dependent On The Member's Eligibility For Benefits And Is Subject To Deductible, Co-Insurance And Benefit Plan Limits. Please verify benefits and eligibility by calling the Absolute Total Care Eligibility Line at (866) 912-3604 or via our website at www.absolutetotalcare.com