

REQUEST FOR EXCEPTION OF USE OF FREE STANDING LABORATORY OR RADIOLOGY FACILITIES  
\*\*\*\*\*RETRO LABORATORY OR RADIOLOGY REVIEW\*\*\*\*\*

**Maryland Physicians Care Prior Authorization Form**

Ph # 1-800-953-8852

Fax # 1- 800-953-8856

Inpatient Fax # 1-800-385-4169 (unscheduled admits)

\*\*\*\*\*Please note: Turnaround Time for Prior Authorization Requests: 2 Business days when all information is received and 7 calendar days when additional information is required.\*\*\*\*\*

Date of Request: \_\_\_\_\_ Authorization Reference # \_\_\_\_\_

For Emergent (life threatening) or Urgent (required within 48 hours) request, please contact the plan at 800-953-8852.

**MEMBER INFORMATION**

Name: \_\_\_\_\_ ID #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ PCP Name: \_\_\_\_\_  
Other Insurance: \_\_\_\_\_ Gender (circle one) **F** **M**

**REFERRING PHYSICIANS OR PROVIDER INFORMATION**

Referring Provider/Requesting Provider	Consulting Provider / Facility
Name: _____	Name: _____
Address: _____	Address: _____
Telephone #: _____	Telephone #: _____
Fax #: _____	Fax #: _____
Contact Person: _____	Specialty _____
Signature of Requesting Physicians: _____	

**REFERRAL / AUTHORIZATION INFORMATION**

Problem / Diagnosis (ICD-9 Code(s) Required): \_\_\_\_\_

Procedure / Test Requested (CPT Code(s) Required): \_\_\_\_\_

Date of Appointment or Service: \_\_\_\_\_ Number of Visits Required: \_\_\_\_\_

Type of Procedure (circle one)    Inpatient    Outpatient    In-Office

Please explain the medical necessity of using hospital-based laboratory or radiology over a free standing facility  
Include Clinical Notes, Lab and X-ray Reports, etc (Please attach additional pages as necessary):

\*NOTE: Date of service must be within 48 hours of request.