

Maryland Physicians Care Prior Authorization Request 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. Please use our prior authorization requirement search tool on our secure provider web portal, via our website at www.marylandphysicianscare.com to verify PA requirements before submitting the PA request. You can also submit prior authorization requests via this secure provider web portal.*******

Date of Request: _____ Authorization / Reference #: _____

For URGENT (life threatening) requests, please contact the plan at 1-800-953-8852.

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____ PCP Name: _____

Other Insurance: _____ Gender (circle one): **F** **M**

REFERRING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider / Requesting Provider

Consulting Provider / Facility

Name: _____ Name: _____

Tax ID: _____ Tax ID: _____

Address: _____ Address: _____

Telephone #: _____ Telephone #: _____

Fax #: _____ Fax #: _____

Contact Person: _____ Specialty: _____

Signature of Requesting Physician: _____

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

Other Clinical Information - Include Clinical Notes, Lab and X-ray Reports, etc (For procedures, please attach additional pages as necessary): _____

***NOTE: FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY, INCLUDE A PRICING LIST FOR DME AND CORRECT CPT CODES WILL RESULT IN THE RETURN OF THIS REQUEST UNPROCESSED.**

Updated: 2/23/2011