

Maryland Physicians Care Prior Authorization Form
Ph # 1-800-953-8852 (urgent or emergent request, date of service 7 days or less)
Non Urgent Fax # 1- 800-953-8856 (date of service greater than 7 days)
Inpatient Fax # 1-800-385-4169 (unscheduled admits)

Date of Request: _____ Authorization / Reference #: _____

For Emergent (life threatening) or Urgent (required within 24 hours) request, please contact the plan at 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: _____
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 INCLUDE CORRECT CPT AND ICD-9 CODES MAY RESULT IN THE RETURN OF THIS FORM UNPROCESSED.**

For Administrative Purposes Only:	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Date: _____
Reason for Denial: _____			
Revised 5/15/07			