Medical/Surgical Prior Authorization Request Form

Return fax to: 855-313-3106 (or secure email to ecs@superiorvision.com)

Date of Request: _____

Patient Information:	**Provider Information:**
Patient Name: _____	Rendering Provider Name: _____
Member ID: _____	Individual Provider NPI: _____
Date of Birth: _____	Rendering Tax ID: _____
Other Primary Insurance Information:	Rendering Provider Address: _____
Health Plan Name: _____	Contact Name: _____
Health Plan Product: _____	Phone Number: _____
Medicare primary? ☐Yes ☐No	Fax Number: _____

- **Please include medical records with all requests.**
- **Legible clinical notes within the last six months are required.**
- **Medical records must be signed and finalized.**

Requested Services:

Date of Service: _____

CPT: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

CPT: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

CPT: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

CPT: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

CPT: _____ ☐OD ☐OS ☐OU Diagnosis Code(s): _____

Facility/Office Name: _____

Facility/Office Phone Number: _____

Circle Facility Type: ☐OUTPATIENT ☐IN OFFICE ☐ASC ☐EMERGENCY ROOM

By checking the following box, you are certifying a decision rendered under the standard timeframe could jeopardize the patient's life, health (vision), or ability to regain maximum function and an expedited/urgent determination is required. This reason should not apply to routine services ☐

Medical indication for urgent request: _____