ENGAGED HEALTH GROUP

Prior Authorization Request

Please attach any supporting clinical documentation and fax to EHG at 443-383-6300

Contact Information:

Sender Name:	
Phone:	
Fax:	

Patient Information:

Name:	**Phone:**
DOB:	**Address:**
Member ID:	

Referring Provider Information:

Name:	**Phone:**
Address:	**Fax:**
NPI:	**TIN:**

Treating Provider Information:

Name:	**Phone:**
Address:	**Fax:**
NPI:	**TIN:**

Treating Facility Information:

Name:	**Phone:**
Address:	**Fax:**
NPI:	**TIN:**

Services Requested:

Place of Service:	
CPT codes:	
Units/Days requested:	
Diagnosis:	
Date of Service:	

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Instructions:

1. **All fields must be completed. If not applicable, please note N/A. Failure to complete the form in full may delay request entry and completion of review.**

2. **Include clinical documentation which supports the requested services at time of the request for the quickest turnaround time. Failure to include appropriate clinical data may delay completion of the review.**

3. **Fax all information (this form and clinical documentation) to EHG at 443-383-6300**

4. **You may also submit your request via email to ehghum@engagedhealthgroup.com**