



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](mailto:ehghum@engagedhealthgroup.com)**