

**PRIOR AUTHORIZATION FORM**

Utilization Management Department Phone: 305/575-3650

An authorization is valid for 60 days from the date issued.

- JM Health Plan     SFCCN (PSN-PHT)     CMSN-PHT     Flex Plan

**An authorization is not a guarantee of payment.**

**MEMBER/ENROLLEE INFORMATION**

Member/Enrollee's Name:	D.O.B:
Member/Enrollee ID :	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Member/Enrollee's Address:	Phone:

**REQUESTING PROVIDER INFORMATION**

Provider Name:	Specialty:	Provider ID:
Form completed by:	Date:	
Telephone Number:	FAX Number:	

**REFER TO PROVIDER/FACILITY INFORMATION**

Provider Name:	Specialty:	Provider ID:
Telephone Number:	FAX Number:	
Office Location:		

**TYPE OF SERVICE INFORMATION**

Type of Service:	<input type="checkbox"/> Consult/Follow-up	<input type="checkbox"/> Procedure	<input type="checkbox"/> Inpatient Admission	<input type="checkbox"/> Surgical	<input type="checkbox"/> Other
Level of Service:	<input type="checkbox"/> STAT (emergency/inpatient) *allow 4 hours	<input type="checkbox"/> Urgent *allow 1 business day	<input type="checkbox"/> Routine/Non Urgent *allow 2 business days		

Date of Appointment:	Number of Visits:
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Diagnosis:

ICD-9 Code 1	Code 2	Code 3
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Tests/Procedures:

CPT Code 1	Code 2	Code 3
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Clinical Summary and Pertinent Facts to Support Your Request:

additional info attached

**Fax All Requests To Utilization Management: 305/575-3761**  
**ALL FIELDS MUST BE COMPLETED IN ORDER FOR REQUEST TO BE PROCESSED.**

**PROCESSING INFORMATION (For Division Of Managed Care Use Only)**

<input type="checkbox"/> Approved	Authorization No:	Expires:
<input type="checkbox"/> Denied	Reason:	
<input type="checkbox"/> Pended for Additional Information/Justification (Do not exceed 5 business days)	Medical Director Sign Off:	