PRIMETIME HEALTH PLAN PREAUTHORIZATION AND REFERRAL FORM

PCP must make initial referral.
PCP or Spec. may extend referrals.

PrimeTime Health Plan
P.O. Box 6905
Canton, OH 44706
Phone: (330) 363-7407
Fax: (330) 363-2350

PREAUTHORIZATION NEEDS TO BE RECEIVED BEFORE THE REFERRAL APPOINTMENT!

*****ALL FIELDS ARE MANDATORY AND REQUIRE COMPLETION FOR PROCESSING*****

Patient: _____Date of Birth _____ Today's Date: _____

Group Number: _____ I.D. Number: _____

Out Of Network specialist/facility:

Full Name: _____ Diagnosis: _____

Tax ID:_____ ICD-9/ICD-10:_____

NPI:_____ Procedure: _____

Specialty:_____ CPT:_____

Address:_____

Telephone:_____ Fax:_____

****Please include office/visit noted that will provide additional history relative to this referral****

_____

Date Physician Requesting Referral (Please print full name) Phone Number Fax Number

_____

Address of Requesting Physician Tax ID NPI

_____

Physician's Signature Are you the Primary Care Office? Yes or No Person filling out referral

Service Requested: ☐ **Office Visit** ☐ **Inpatient** ☐ **Outpatient** ☐ **Ambulatory Surgery** ☐**Other**_____

_____Consultation and Evaluation/ Date of Service (if known): Date _____/_____/_____

_____Second Opinion / Date of Service (if known): Date _____/_____/_____

_____Treatment / Procedure / Test (Specify Code:_____

_____ Patient Requested Specialist – Specialist and/or Out-of-Network Visit Not Necessary

****An updated plan of care and progress note must be submitted with request for continued services****

Note: A preauthorization does not guarantee payment or authorize coverage for services not covered through the member's benefit plan. Claims are subject to review upon receipt of the claim/documentation. Reviewed: 11/02; 1/05; 4/06; 5/10; 6/11; 3/13; 5/14; 3/15; 2/18