

# GENERIC PRIOR AUTHORIZATION FORM

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

## Patient Information:

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Prescriber Information:

Prescriber Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

## Medication and Treatment Information:

Medication Name: \_\_\_\_\_

Dosage and Strength: \_\_\_\_\_

Quantity Prescribed: \_\_\_\_\_

Frequency: \_\_\_\_\_

Duration of Therapy: \_\_\_\_\_

## Diagnosis and Clinical Information:

Please provide the diagnosis code(s) and clinical rationale supporting the medical necessity of this medication or treatment. Include relevant history, prior treatments, and response to therapy, if applicable.

## Supporting Documentation:

Attach all relevant medical records, lab results, imaging, and other pertinent information required for review. Failure to provide complete information may delay processing of this authorization request.

## Prescriber Signature and Certification:

By signing below, I certify that the information provided is true and accurate to the best of my knowledge. I attest that the requested treatment is medically necessary and that no alternative treatments are appropriate or effective.

Prescriber Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## For Office Use Only:

Date Received: \_\_\_\_\_ Authorization Number: \_\_\_\_\_

Reviewer Name: \_\_\_\_\_

Approval Status: \_\_\_\_\_

Comments: \_\_\_\_\_

**1. Authorization Validity**

This authorization is valid only for the specified medication or treatment, patient, and duration as approved. Any changes require a new authorization.

**2. Medical Necessity**

The prescriber certifies that the requested medication or treatment is medically necessary and meets all applicable clinical criteria.

**3. Confidentiality**

All patient and prescriber information submitted is confidential and will be used solely for the purpose of processing this prior authorization request.

**4. Compliance with Laws**

This form and the prior authorization process comply with all applicable federal and state laws and regulations.

**5. Denial and Appeal Rights**

In case of denial, the prescriber and patient have the right to appeal the decision following the payer’s established procedures.

**6. Accuracy of Information**

Providing false or misleading information may result in revocation of authorization and possible legal penalties.

**7. No Guarantee of Payment**

Authorization approval does not guarantee payment or coverage by the insurance plan.

**8. Patient Responsibility**

The patient is responsible for any applicable co-payments, deductibles, or non-covered services as per the insurance plan’s terms.

**PRESCRIBER SIGNATURE**

**REVIEWER SIGNATURE**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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