Prior Authorization Request Form
Fax to: 833-332-1877

Please be aware that you may submit all inquiries for prior authorization requests via the eQSuite® Provider Portal at https://apexhealth.okta.com/. eQSuite® Provider Portal is an all-access entry into your prior authorization requests and determinations.
For questions about using the portal and UR/Prior Authorizations, please contact ApexHealth at: **800-707-8593.**

Contact Information

Contact Name	Phone	Fax	Date

General Information

Severity: ☒ Standard ☐ Urgent ☐ Emergent (Head in Bed)

Clinical Reason for Urgency:

Review Type: *Check all that apply*

☐ PR/SNF (Same Day Transfer) ☐ Inpatient ☐ Initial ☐ Concurrent
☐ Transplant ☐ Outpatient ☐ Retrospective ☐ Future Admit

Patient Information

M

Name | DOB | Address

Subscriber Name (If Different) | Member ID | Sex

Provider Information *Please complete both requesting and servicing sections below *

Requesting Provider/Facility (REQUIRED)	Servicing Provider/Group/Facility (REQUIRED)
Name	Name
**NPI (Required)	**Tax ID (Required)
**NPI (Required)	**Tax ID (Required)
Phone	Fax
Phone	Fax
Address (**Required for Mailing Denial Letter)	Address (**Required for Mailing Denial Letter)

Procedure Information

Planned Service/DME/Admission	CPT Code	DOS	Number of units/visits	Main Diagnosis	ICD 10 Code

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Additional Clinical Explanation

***Please attach clinical documentation to faxes such as signs, symptoms, history, diagnostic test results, consultant recommendations (if applicable), and plan of treatment. Requests *cannot* be processed without this documentation. ** Comments:**

Severity Clarification:
**** Emergent:** Direct Admission; the member is currently in the hospital; "head in the bed" at the time of request

Additional information and instructions:
The requesting provider listed above will be contacted if there are any questions. If approved the form will be faxed back to this fax number. If denied, the denial letter will be faxed to this number and mailed to the "requesting physician".

Disclaimer Statement
ApexHealth certification determination does not guarantee payment for services. Eligibility for and payment of services are subject to all terms, conditions and limitations of the Summary Plan Description.

Requesting Provider Attestation Statement
I hereby attest that, as a healthcare services provider or provider's representative, an order for the above medical services has been received for the identified member. In addition, I attest that the treatment plan has been approved by the prescribing (ordering) physician.

Printed Name: _____ *Signature:* _____ *Date:* _____ / _____ / _____

Prior Authorization Contact: 800-707-8593