Prominence® Health Plan

PRIOR AUTHORIZATION REQUEST FORM

In order to process the request, please complete the entire form and include all clinical records. This referral/ authorization is not a guarantee of payment. Payment is contingent upon eligibility.
Fax the form to one of the following numbers based on member enrollment:

MEDICARE 813-513-7304 | COMMERCIAL FULLY INSURED 775-770-9122 | ASO SELF-FUNDED 775-770-9037

FORM TYPE:
☐ Standard - Medicare 14-day turnaround; Part B Drug 72-hour turnaround; Commercial 15-day turnaround
☐ Retrospective - 30-day turnaround
☐ Concurrent Review - 24-hour turnaround
☐ Hospital Discharge Assistance
☐ Medicare Expedited Part B Drugs - 24-hour turnaround
☐ Medicare Standard Part B Drugs - 72-hour turnaround

☐ **URGENT/EXPEDITED - 72-hour turnaround for Medicare/Commercial / 24-hour turnaround for Part B Drugs**
Check here to attest that the member's condition meets one of the following:
☐ Seriously jeopardize the life or health of the member
☐ Seriously jeopardize the member's ability to attain, maintain or regain maximum function

NOTE! An Urgent/Expedited request may be processed as standard if it does not meet at least one of the criteria listed above.

Member Name (Last, First, Middle Initial)		Member DOB (MM/DD/YY)
Member ID #	Plan/Group #	Primary Care Provider

PLAN TYPE: ☐ Medicare Advantage ☐ Commercial ☐ Self-funded

STATE: ☐ Nevada ☐ Texas ☐ Florida

ORDERING/REQUESTING PROVIDER INFORMATION:

Provider Name	Contact at Provider Office	Requesting Facility
Provider NPI #	Provider Phone #	Provider Fax #

SERVICING PROVIDER/FACILITY: ☐ Inpatient ☐ Outpatient ☐ Office ☐ DME/HH

Provider Name	Type of Provider/Specialty	Facility Name

Provider NPI #	Provider TIN#	Provider Phone #	Provider Fax #
Servicing Provider Contact		Provider Specialty/Facility Type	
ICD 10 Codes:			

All column fields MUST be completed. DO NOT LEAVE BLANK.

Description of Requested Service or Medication Name	CPT/HCPCS/J CODES	Start Date	End Date	Visits/Units

Medication Requests (if applicable)	Dose (mg, etc.):	Frequency (every 4 weeks, etc):	Continuation Request (y/n):

Additional Required Information for Medicare Requests

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.