

**HEALTH SERVICES
PREAUTHORIZATION
REQUEST FORM**



**Please fax completed
form and chart notes to:
(208) 333-1597**

A determination notice will be mailed and/or faxed to the requesting provider, facility, and patient.

- PacificSource responds to preauthorization requests within two (2) working days.
- Requests received after 3:00 p.m. are processed the next work day.
- Incomplete requests will delay the preauthorization process.
- Please include pertinent chart notes to expedite this request.

REQUESTING PROVIDER CONTACT INFORMATION

Contact person: _____

Date: _____ Phone: (____) _____ Fax: (____) _____

PATIENT INFORMATION

Last name: _____ First name: _____

DOB: _____ Member #: _____

PROCEDURE INFORMATION

CPT / HCPCS procedure codes: _____

Description: _____

Description: _____

ICD-9 Diagnoses codes: _____

Description: _____

To be scheduled Dates of service: _____

Outpatient Inpatient Requested length of stay: _____ days

Assistant surgeon requested? Yes No Is this a retrospective request? Yes No

PROVIDER INFORMATION

Ordering physician/provider: _____

Office address where preauthorization should be sent: _____

City/State: _____ Tax ID: _____

Fax #: (____) _____ Phone: (____) _____

Place of service or vendor name: _____

Office address where preauthorization should be sent: _____

City/State: _____ Tax ID: _____

Fax #: (____) _____ Phone: (____) _____

Health Services Department
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