



FirstCare Prior Authorization Request Form

(DME, Inpatient Notification, Medical Drug, OON Referral, Prior Authorization)

SECTION I — Submission

Issuer Name: FirstCare Health Plans	MEDICAL/ DME Phone: 800-884-4905 Fax: 800-248-1852	Mental Health/Substance Abuse Phone: 800-327-6943 Fax: 512-233-5949	Date:
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SECTION II — GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment <input type="checkbox"/> Over-The-Benefit-Limit	Prev. Auth. #:

SECTION III — MEMBER INFORMATION

Member Name:	Phone:	DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber Name (if different):	*Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider			Service Provider or Facility		
Name:	Specialty:		Name:	Specialty:	
Ind. NPI:	TPI:		Ind. NPI:	TPI:	
Group NPI:	TIN:		Group NPI:	TIN:	
Contact Name:			Address:		
Phone:	Extension:	Fax:	Contact Name:		
Primary Care Provider Name:			Phone:	Extension:	Fax:

SECTION V — SERVICES REQUESTED AND SUPPORTING DIAGNOSES

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description	DX Code

Number of visits/ units/ days: _____ Modifiers: _____

Referral Inpatient Outpatient Day Surgery Observation Other: _____

Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehab Mental Health/Substance Abuse

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

Home Health (MD Signed Order Attached? Yes No) (Nursing Assessment Attached? Yes No)

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

DME (MD Signed Order Attached? Yes No) (Medicaid only: Title 19 Certification Attached? Yes No)

Rental Purchase

SECTION VI — CLINICAL DOCUMENTATION (Narrative of medical necessity or attach supporting clinical records.)