

## Prior Authorization Request Form

Please include supporting clinical documentation with your request. Submissions without clinical documentation will be considered incomplete. Submit completed forms via fax at 833-840-3414 or email to [preauthcommercial@slhealthplan.org](mailto:preauthcommercial@slhealthplan.org). Questions? Contact St. Luke's Medical Management at 833-840-1222.

Please note: Prior authorization is not a guarantee of payment; payment is subject to member eligibility and benefits at the time of service.

1. MEMBER/PATIENT INFORMATION			
First Name	Last Name	Middle Name	Date of Birth
Member ID	Group ID	Group Name	

2. PROVIDER INFORMATION		
Referring Provider Name	Address	
Referring Provider NPI	Specialty	
Office Contact Name	Phone Number	Fax Number
Servicing Provider Name	Address	
Servicing Provider NPI	Phone Number	Fax Number
Specialty	Facility NPI	
Facility Name	Facility Address	
Tax ID	Phone Number	Fax Number

3. SERVICE REQUESTED			
Inpatient	Outpatient	Clinical Urgency:	Standard    Urgent    Emergent Inpatient Admission
Primary Diagnosis			
Code/Description		Date of Service	
Services Requested			
Code/Description		Number of Units	
Code/Description		Duration	