

Medical Procedure/Surgery

PRIOR AUTHORIZATION FAX REQUEST FORM



Attn: Medical/Surgical- Pre-D Coordinator
Toll Free Phone Number: 1-800-891-2520
Fax: 567-661-0846

Date of Request: _____

Member Name: _____

DOB: _____

Paramount Member ID#: _____

Paramount Secondary ID#: _____
(if applicable)

Ordering Physician: _____

Contact Person: _____

Phone #: _____

Fax #: _____

NPI: _____

Provider Billing Tax ID (TIN): _____

ICD-10: _____

CPT Code(s): _____

Description of Procedure/Testing: _____

Continuation of Care Request (Concurrent Review): Yes: _____ No: _____.

If yes, please include previous authorization approval number: _____

Solid Organ Transplant Request Yes ____ No ____

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Date of Procedure/Testing: _____

Name of Facility: _____

Address: _____

Telephone Number: _____

Fax Number: _____

NPI #: _____

Tax ID# _____

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Please send the following information

- Brief medical/clinical history
- Current signs and symptoms
- Results of any pertinent diagnostic testing

PLEASE NOTE PARAMOUNT IS NO LONGER ABLE TO REVIEW FOR RETRO DATES OF SERVICE

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