Medical Procedure/Surgery

PRIOR AUTHORIZATION FAX REQUEST FORM

PARAMOUNT
ELITE | COMMERCIAL/HMO

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 ___

Date of Procedure/Testing: _____

Name of Facility: _____ Address:_____

Telephone Number: _____ Fax Number:_____

NPI #: _____ Tax ID#_____

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

Revised Date: 5/2024