

**OUT OF PLAN Prior Authorization**

Attn: Out-of-Plan Coordinator

Toll Free at (800) 891-2520

Fax: 567-661-0847



**PARAMOUNT**

ELITE | COMMERCIAL/HMO

Date of Request: \_\_\_\_\_

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Paramount ID#: \_\_\_\_\_ Secondary Paramount ID#: \_\_\_\_\_  
(If applicable)

Ordering Physician: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

NPI: \_\_\_\_\_ Provider Billing Tax ID (TIN): \_\_\_\_\_

State Reason for going out of network: \_\_\_\_\_

Continuation of Care Request (Concurrent Review): Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please include previous authorization approval number: \_\_\_\_\_

Solid Organ Transplant: Yes ☐ No ☐

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Date of Appointment or length of stay: \_\_\_\_\_

Requested Services: \_\_\_\_\_

CPT Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**Out of Plan Physician Name and Specialty:** \_\_\_\_\_

Physician NPI#: \_\_\_\_\_ Physician Tax ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Out of Plan Facility Name:** \_\_\_\_\_

Facility NPI #: \_\_\_\_\_ Facility Tax ID# \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please send the following information:

- ✓ Brief medical/clinical history
- ✓ Current signs and symptoms
- ✓ Results of any pertinent diagnostic testing
- ✓ Referring physician's expectation of the out-of-plan referral
- ✓ Consult or treatment documentation from in-plan or approved out-of-plan specialist

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