P.O. Box 6905
Canton, OH 44706
Phone: (330) 363-7407
Fax: (330) 363-2350

PRIMETIME HEALTH PLAN PREAUTHORIZATION AND REFERRAL FORM

PCP must make initial referral.
PCP or Spec. may extend referrals.

PREAUTHORIZATION NEEDS TO BE RECEIVED BEFORE THE REFERRAL APPOINTMENT!

*****ALL FIELDS ARE MANDATORY AND REQUIRE COMPLETION FOR PROCESSING*****

Patient: ______________________________ Date of Birth ______________ Today's Date: _________________________________

Group Number: ________________________________ I.D. Number: ___________________________________

Out Of Network specialist/facility:

Full Name: ____ Diagnosis: ____________________________________

Tax ID:____ ICD-9/ICD-10:_________________________________

NPI:____ Procedure: ____________________________________

Specialty:____ CPT:____

Address:____

Telephone:____ Fax:____

****Please include office/visit noted that will provide additional history relative to this referral****

Date **Physician Requesting Referral (Please print full name)** **Phone Number** **Fax Number**

Address of Requesting Physician **Tax ID** **NPI**

Physician's Signature **Are you the Primary Care Office? Yes or No** **Person filling out referral**

Service Requested: ☐ **Office Visit** ☐ **Inpatient** ☐ **Outpatient** ☐ **Ambulatory Surgery** ☐ **Other**___________________

_____**Consultation and Evaluation/ Date of Service (if known): Date** _____/_____/_____

_____**Second Opinion / Date of Service (if known): Date** _____/_____/_____

_____**Treatment / Procedure / Test (Specify Code:**____

_____**Patient Requested Specialist – Specialist and/or Out-of-Network Visit Not Necessary**

****An updated plan of care and progress note must be submitted with request for continued services****

Note: A preauthorization does not guarantee payment or authorize coverage for services not covered through the member's benefit plan. Claims are subject to review upon receipt of the claim/documentation.