Medical Prior Authorization Request

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sanfordhealthplan.com

SANFORD HEALTH PLAN

Please complete, sign and date this form. Effective **10/1/20** we will be requesting that prior authorization requests be sent via our portal on sanfordhealthplan.com. For instructions on how to request this access to the portal, please email providerrelations@sanfordhealth.org.

Patient Information

Member Name:	Member ID#:
Address:	City, State, Zip Code:
DOB:	Phone Number:

Provider/Vendor Information

CPT Codes/HCPC Codes:	Inpatient: ○ Outpatient ○
Date of Service:	Retro: ○ Yes ○ No
Primary Diagnosis – ICD-10:	Secondary Diagnosis – ICD-10:

Ordering Provider	Referred To Provider/Facility
Ordering Provider Name: _____	Referred to Provider Name/Facility: _____
Specialty: _____ ☐ No specialty	Specialty: _____ ☐ No specialty
Tax ID number:	Tax ID number:
NPI number:	NPI number:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:
Contact person at referring provider's office:	Contact person at referred to provider's office:
Phone Number: / Fax Number:	Phone Number:

Clinical Information Submitted for Determination

Determination will be based on individual plan policy and clinical documentation submitted. Include all pertinent clinical documentation to support the request. Check all that apply.

- ☐ Letter of Medical Necessity
- ☐ Current Clinical Notes
- ☐ Labs
- ☐ Diagnostics Report
- ☐ Diagnostic CDs
- ☐ Colored Photos
- ☐ Durable Medical Equipment Form
- ☐ Other

Signature

Codes not requested at time of service may result in a denied claim.

Requesting Person/Authorized Representative Signature:	Date Submitted: