Cleveland Clinic

MEDICAL MANAGEMENT PRIOR AUTHORIZATION REQUEST

EHP Medical Management
Fax: 216-442-5791
Phone: 216-986-1050 Toll Free 888-246-6648

Please attach this form to the medical records that support the request. Completion of this form does not guarantee approval. Requests are reviewed based on provided information. Decisions will be faxed to the requesting provider.

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST)	DOB	INSURANCE ID#

PROVIDER INFORMATION

REQUESTING CONTACT NAME/TITLE	PHONE NUMBER	FAX NUMBER
REQUESTING PROVIDER/FACILITY	**ADDRESS**	**NPI #**
SERVICING PROVIDER/FACILITY	**ADDRESS**	**NPI #**

PROCEDURE/SERVICE(S) REQUESTED

INPATIENT	OUTPATIENT	
ACUTE _____	LAB(S) _____	HOME
SNF _____	IMAGING _____	HEALTHCARE _____
REHAB _____	DME _____	
LTAC _____		OTHER _____

SERVICE DESCRIPTION:	CPT/PROCEDURE(PX)/HCPCS CODE(S):
DATE OF SERVICE:	**DIAGNOSIS(DX)CODE(S):**

EXTENSION OR CHANGE REQUEST

REFERRAL/AUTH #	DESCRIPTION OF CHANGE REQUESTED

CONFIDENTIAL PHI-INCLUDE COVER SHEET