Fax completed form to **616.975.0249** Questions? Call our Provider Helpline at 800.942.4765. Priority Health

Behavioral health prior authorization form

☐ Check if requesting on behalf of a Cigna-participating provider

Missing or incomplete information, including required clinical documentation, may result in delays.

Date: _____

Type of service

☐ Initial psychosocial assessment / evaluation / medications – *attach clinical documentation*		
☐ Concurrent review – *attach clinical documentation*	Authorization #	
☐ Discharge – *provide discharge information below*	Authorization #	
☐ Retrospective review – *attach clinical documentation*	Authorization #	
☐ Medicare organization determination		

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	
Phone #			

Level of care

☐ MH Inpatient ☐ MH IOP ☐ SUD Detox ☐ SUD IOP
☐ MH Residential ☐ MH OP ☐ SUD Residential ☐ SUD OP
☐ MH Partial Hosp. ☐ SUD Partial Hosp.

☐ Check if you have **24/7 onsite nursing** for MH Residential/SUD inpatient services?*
**If no, explain why in the Additional Information field below. Please note "onsite" doesn't mean "on call".*

Date(s) of service	From:	To:	
SW/case manager name		Discharge date – *if applicable*	
SW/case manager phone #		Attending psychiatrist	
Diagnosis code(s)		Procedure code(s)	

Provider / facility information

Provider name		Facility name	
Provider TIN		Facility TIN	
Provider NPI		Facility NPI	
Address			

Contact

Name		Title	
Phone		Fax	

Follow-up care

Therapist name		PCP name	
Therapist appt. information		PCP appt. information	
Psychiatrist name		Treatment order in place?	
Psychiatric appt. information		Other	

Additional information / discharge medications – *name, dose, frequency*

Print