Elderwood Health Plan
Request for Prior Authorization Form

Call: 1-855-200-6247
Or FAX 716-633-1153
Or by secure e-mail
HealthPlaninfo@elderwood.com

Date of Request: _____

MEMBER INFORMATION

Name: _____

ID Number: _____

Date of Birth: _____

Phone Number: _____

REQUESTING PROVIDER INFORMATION

Referring Provider / Requesting Provider Place of Service or Facility Name

Name: _____

Address: _____

Telephone #: _____

Fax #: _____

Specialty: _____

National Provider Identification (NPI): _____

Contact Person: _____

REFERRAL / AUTHORIZATION INFORMATION

Problem / Diagnosis/ ICD-9 Code(s):

_____

_____

Service Requested /CPT Code(s):

_____

_____

Date of Appointment or Service: _____

Number of Visits Required: _____

Medical need justification /Other information/Special instruction:

_____

_____

_____

_____