Elderwood Health Plan

Request for Prior Authorization Form

Call: 1-866-843-7526 Date of Request: _____

Or fax: 716-568-8378

Or send by secure e-mail: EHPUM@elderwood.com

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:

_____

_____

_____

_____