



Prior Authorization Fax Form
 Complete this Form and Fax to 1-877-650-6943
 Incomplete Forms Will Be Returned for Resubmission

- Standard Request**-(determination within 2 working days of receiving all necessary information)
- Urgent Request** – By checking this box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening) which must be treated within 24 hours.
 ALL URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN, IN ORDER TO BE PROCESSED AS AN URGENT REQUEST

Signature of Requesting Provider

Requesting Provider Name: _____ **Requesting Provider Tel:** _____
Requesting Provider Fax: _____ **Date of Request:** _____

Patient Information		
Name (Last, First, Middle Initial):	Date of Birth:	
Member Medicaid ID#		
Other Insurance? (if Yes) Name and Policy #:		
- Must Be Completed -		
Referring To Specialist and /or Facility: <input type="checkbox"/> Participating <input type="checkbox"/> Non-Participating		
Specialist / Facility Name:	Specialty / Facility Type:	
Address/Location:		
City:	Zip:	Telephone:
Purpose of Referral:		
<input type="checkbox"/> Consult Only	<input type="checkbox"/> Diagnostic / Radiology	<input type="checkbox"/> Therapy PT/OT/ST
<input type="checkbox"/> Consult w/Treatment	<input type="checkbox"/> Outpatient Surgery	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Follow-up Visit	<input type="checkbox"/> Inpatient Admission	
<input type="checkbox"/> Consult & Follow-up Visit		
PLEASE SEND WITH THIS FORM COPIES OF APPROPRIATE SUPPORTING CLINICAL INFORMATION FOR ALL CASES		
Diagnosis / Reason:	ICD-9 Code(s):	
Service/Procedure Requested/CPT Code:	Requested Dates of Service:	
TO BE USED BY HEALTH PLAN STAFF		
Approved: _____ Units approved: _____		Decision Date: _____
Authorization Number: _____		Reviewer: _____
Authorization Start Date: _____		
Authorization End Date: _____		
Denied _____		Prior Authorization Dept. Phone Number 1-866-912-6285

Disclaimer: Authorization is contingent upon the following: At the time services are rendered, beneficiary is eligible for services and services are a covered Magnolia Health Plan Benefit. An authorization is not a guarantee of payment. All services must be coordinated by the Primary Care Physician. **Please mail or fax a copy of the consultation/follow up report to the PCP within 5 business days of visit.**

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Member Rights and Responsibilities: Per Mississippi Medicaid, all providers are to be knowledgeable of the rights and responsibilities for those receiving Mississippi Medicaid. Their rights and responsibilities are listed within Magnolia's Provider Manual. To view the Provider Manual, please visit Magnolia's website, www.magnoliahealthplan.com, or request a copy of the Provider Manual through your Provider Services Representative at 1-866-912-6285.