Prior Authorization Request

***Complete and submit with all supporting clinical documentation*: Fax: 1-833-947-7577**

For questions call Ochsner Health Plan Utilization Management Department at 1-833-777-0933

Date of Submission

EXPEDITED REQUEST ☐

Who We Can Contact for Additional Information (*Denotes required field*)		
***Responsible Party**		**Department**
***Return Phone**	**Ext**	**Fax**

Member Information		
***Member's Full Name**		***DOB**
Ochsner Health Plan Member ID		***Plan Coverage** **Medicare Advantage** ☐ **D-SNP** ☐
***Member Phone**	**AOR Name, *if applicable***	***AOR Phone***

Provider Information		
***Requesting Provider and NPI**	***Phone**	***Fax**
***Servicing Provider (and NPI)/Vendor** ☐ *Same as Requesting Provider*	***Phone**	***Fax**

Service Type(*Denotes required field*)									
Visits	☐	**DME**	☐	**Therapy**	☐	**Home Health**	☐	☐	**Part B drug** ☐
How many/how frequent?									

***Principal Diagnosis**	
***ICD-10 Code(s)**	***CPT Code(s) *HCPCS Code(s)**

Outpatient Information (*Denotes required field*)	
***Specific Service/Item Requested**	
***Start Date of Service**	***End Date of Service**

Inpatient Information (*Denotes required field*)									
Acute	☐	**LTAC**	☐	**Acute Rehab**	☐	**Skilled Nursing**	☐	**Other**	☐

***Admission Date**	***Discharge Date, *if applicable***
***Facility Name**	
***Address**	
***Tax ID #**	
***Admitting/Attending Physician and NPI**	**Physician Specialty**

Contracted Providers must use the Ochsner Health Plan Provider Portal. Not all services listed will be covered by the benefits in a member's health plan product. This form does not replace Ochsner Health Plan's specific prior authorization requirements.

CLEAR FORM