Prior Authorization Request
For Procedures and Services

Instructions for Completing this Request

Submit this completed form to MVP Health Care® via email to **authorizationrequest@mvphealthcare.com** or fax it to MVP Utilization Management Department at **1-800-280-7346**. All supporting medical documentation and/or any additional pertinent information should be included when submitting this form.

Payment for services/items dispensed will be denied when prior authorization is not obtained. The Member may not be billed under these circumstances.

Section 1: MVP Member Information

*(*Required Information)*

Member Name* | Date of Birth* | MVP Member ID No.* | Vermont Resident?* ☐ **Yes** ☐ **No**

Is this Request a clinical emergency?* ☐ **Yes** ☐ **No**

Section 2: Requesting Provider Information

*(*Required Information)*

Requesting Provider Name* | NPI No.* | Tax ID No.* | Phone No.*

Contact Name* | MMIS No. *(Medicaid/CHPlus Only)* | Fax No.*

Office Street Address* | City* | State* | Zip Code*

Section 3: Servicing Physician/Facility Information

*(*Required Information)*

Name* | NPI No.* | Tax ID No.* | Phone No.*

Office Street Address* | City* | State* | Zip Code* | Fax No.*

ICD-10 Code(s)* | **CPT/HCPC** Code(s)*

Procedure/Services Requested*

Date of Service to be Rendered ☐ **To be Determined** | Where is service rendered?* ☐ **Inpatient** ☐ **Outpatient** ☐ **Office** | Is there an existing Authorization?* ☐ **Yes** ☐ **No**

Section 4: Prescriber's Attestation

*(*Required Information)*

I attest that this information is accurate and true, and that the appropriate supporting documentation is provided. I understand that requests submitted without this documentation may be denied or delay the review process. I understand that any person who knowingly makes a false statement that is material to a claim may be subject to civil penalties under both federal and New York State False Claims Acts. Only the prescriber responsible for the treatment and evaluation of the Member, an authorized agent, the Member, or the Member's authorized representative may initiate a prior authorization or organizational determination.

*Prescriber's Signature** *Date**