Prior Authorization Request

For Procedures and Services

Submit this completed form to **authorizationrequest@mvphealthcare.com** or fax it to the 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.

Section 1: MVP Member Information *(*Required)*

Member Name* | Date of Birth* | MVP Member ID No.*

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

Section 2: Requesting Provider Information *(*Required)*

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

Contact Name* | MMIS No. *(Medicaid/Child Health Plus Only)* | Fax No.*

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

Section 3: Servicing Physician/Facility Information *(*Required)*

Name* | Tax ID No.* | NPI 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*

Is this for* ☐ **Inpatient** ☐ **Outpatient** ☐ **Office** ☐ **Existing Authorization?*** ☐ **Yes** ☐ **No**

Section 4: Prescriber's Signature *(*Required)*

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 the NYS 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**

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