Prior Authorization Fax Request Form

Please submit form via: Fax (714-360-0168) OR email (VerdaPriorAuhorizations@verdahealthcare.com)

SECTION I — Submission

Submitter Name and title:	Phone:	Fax:	Date:

SECTION II: Member Information

Name:	DOB:
Phone number:	☐ Male ☐ Female
Verda Member ID number:	IPA/Med Group:
Subscriber Name (if different):	

SECTION III — Review Type

☐ Expedited/Urgent Clinical Reason:	☐ Elective/ Routine	☐ Extension/Renewal/Amendment Previous Authorization #:

SECTION IV — Provider Information

Requesting Provider or Facility		**Service Provider or Facility**	
Name:		Name:	
Address:		Address:	
Phone:	Fax:	Phone:	Fax:
NPI #:	Specialty:	NPI #:	Specialty:
Primary Care Provider Name (see instructions):			

SECTION V — Services Requested.

CPT/HCPC Code(s)	Diagnosis Code (ICD 10) & Description	# of units	Date (s) of service

SECTION VI — Required Clinical Documentation.

Attach supporting clinical information (e.g., medical records, lab reports, progress notes, etc.).