# Prior Authorization Fax Submission Guide

**Overview**
Prior authorization is used to determine the medical necessity of certain healthcare services before they are provided. To ensure coverage, authorization must be requested and approved **in advance**. Services rendered without prior approval may result in claim denial.

**When Is Prior Authorization Required?**
Advance approval may be required for coverage of specific non-emergency services, treatments, or prescriptions.
Examples include:

- Admission to a hospital or skilled nursing facility
- Scheduled surgeries
- Advanced imaging (e.g., MRI, CT scan)
- Durable medical equipment (e.g., wheelchairs, oxygen supplies)

**Do NOT Use This Form To:**

- ✕ Submit an appeal
- ✕ Confirm member eligibility
- ✕ Verify coverage
- ✕ Request a guarantee of payment

**How to Complete the Prior Authorization Request Form**

**SECTION I — Submission Information**
Fill in the details of the person submitting the request:

- Submitter Name & Title
- Direct Phone & Fax Number
- Date: Enter the date the request is being submitted.

**SECTION II — Member Information**
Provide details about the patient receiving care:

- Member Name and Date of Birth
- Members Phone number
- Verda Member ID: This is found on the member's insurance card.
- IPA/Medical Group: located on the insurance card.
- Select Gender : Male or Female.
- Subscriber Info: If different from the patient, provide the subscriber's name

**SECTION III — Review Type**
Choose the appropriate type of review and add relevant details:

- Select Expedited/Urgent, Elective/Routine, or Extension/Renewal/Amendment.

- Clinical Reason: Briefly explain why the service is needed.
- Previous Authorization #: Include for Extension/Renewal/Amendment.

**SECTION IV — Provider Information**
Enter information for both providers involved (if applicable):
***Requesting Provider/Facility***

- Name, Address, Phone, Fax
- NPI Number & Specialty

***Service Provider/Facility (where care will be given)***

- Name, Address, Phone, Fax
- NPI Number & Specialty
- Primary Care Provider Name: Must match Verda Healthcare records.

**SECTION V — Services Requested**
Provide specific codes and dates:

- CPT/HCPC Codes: Procedure codes for requested services.
- Diagnosis Code (ICD-10) & Description
- # of Units: Quantity of services (e.g., visits, tests).
- Date(s) of Service

**SECTION VI — Clinical Documentation**
Include required documents to support the request:

- Medical records
- Lab reports
- Progress notes
- Other relevant supporting information