DOCTORS HEALTHCARE PLANS, INC.

Prior Authorization Form

Submit all requests via fax: (786) 578 -0291 or submit electronically through Provider Portal, www.doctorshcp.com. Urgent, emergent requests telephonically: (305) 422-9300, option 1. The information transmitted herein is intended only for the person or entity to which it is addressed and may contain confidential material. If you receive this document in error, please contact the sender and delete or destroy the material/information.

Patient Information		
PATIENT NAME	DATE OF BIRTH	MEMBER ID #
Requesting Provider Information		
PROVIDER NAME	SPECIALTY	TELEPHONE
TAX ID		
ADDRESS (STREET, CITY, STATE, ZIP)		FAX
Primary Care Physician Information		
PHYSICIAN NAME	TELEPHONE	FAX
TAX ID		
Referral Information		
REFERRED TO PROVIDER NAME	☐ PAR ☐ NON-PAR	TELEPHONE
ADDRESS (STREET, CITY, STATE, ZIP)		FAX
Diagnosis/Complaints		
COMPLAINT/SYMPTOMS		
DIAGNOSIS DESCRIPTION		ICD10 CODES

Services Requested			
PROCEDURE	CPT CODE	PROCEDURE	CPT CODE
ADDITIONAL COMMENTS		DATE OF SERVICE	NUMBER OF VISITS REQUESTED
		REQUESTING PHYSICIAN SIGNATURE (**REQUIRED**)	
Does member require transportation to obtain medical services? Is member ambulatory? ambulatory ☐ wheelchair ☐ stretcher ☐		Indicate type of authorization request: Expedited / Urgent ☐ Standard ☐	
Authorization #:	# of visits approved:	Dates of services approved:	

Supporting clinical documentation may be requested to ascertain benefit coverage determination.
Note: Prior authorization is not a guarantee of payment.