Alignment Healthcare

FirstMedicare Direct
FIRSTCAROLINACARE INSURANCE COMPANY

PRIOR AUTHORIZATION REQUEST

For assistance contact the Referrals/Authorizations Department at: Telephone (844) 215-2442
Please complete the following in its entirety and fax it to: Fax (562) 207-4628

Practice Location: ____________________ Date: __________ PCP: ______________

Priority

☐ Routine	☐ Urgent - Expedited/Urgent is defined: 'in which the routine referral process could seriously jeopardize the life and health of the member, or the member's ability to regain maximum function.'

Health Plan Member ID No.: ______________________

Patients Name (Please Print) Last,	First	Middle	Sex	Date of Birth
Address	City	State	Zip	Telephone

Type of Service (Check, if applicable)

HOSPITAL

☐ Outpatient ☐ Inpatient ☐ Office ☐ DME ☐ Home Health ☐ Dialysis ☐ Chemotherapy

☐ Injectable (MUST INCLUDE NDC)

Referred to Physician/ Facility: ______________________ Specialty: ______________________

Address: ______________________ Phone: ______________ Fax: ______________

Diagnosis: ______________________ ICD-10 Code(s): ________, ________, ________

Procedure: ______________________ CPT Code(s): ________, ________, ________
(Indicate quantities)

Injectable Code: ______________ NDC ______________ Quantity/Units ________

Injectable Code: ______________ NDC ______________ Quantity/Units ________

Additional Codes (Please include NDC and units):

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Attach pertinent progress notes/diagnostic studies to support request

Requesting Physician: ______________________ Telephone No.: ______________________

Person Completing Form: ______________ Telephone No. and Ext.: ______________ Fax No.: ______________

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