



Prior Authorization Request Form
Prior Authorization (General)

Patient Information / Prescriber Information table with fields: Member Name, Bravo ID #, DOB, Address, Prescriber Name, Prescriber Specialty, Prescriber Address, Office Phone#, Office Fax #, Contact Person.

Diagnosis and Medication Requested section with fields: Medication Requested (dosage, frequency), Qty, Prescribing Diagnosis, ICD9 Code, Date Therapy Initiated.

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Please provide rationale supporting request for Prior Authorization.
o If rationale is alternative therapy, please provide clinical documentation supporting :
- Name of alternate therapy, dates and duration of alternate therapy and outcome of each.

REQUIRED EXPLANATION: [Large empty text area for providing rationale]

Failure to provide clinical documentation supporting rationale may result in this request being denied

Request for Expedited Review

REQUEST FOR EXPEDITED REVIEW [24 HOURS]
BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Prescriber's Signature: _____ Date: _____

Fax back to: 866-464-0709 For info call: 877-813-5595
For additional Prior Authorization forms, go to http://www.bravohealth.com/providers.aspx