**Medical Procedure/Surgery**

**PRIOR AUTHORIZATION FAX REQUEST FORM**

Attn: Medical/Surgical- Pre-D Coordinator
Toll Free Phone Number: 1-800-891-2520
Fax: 567-661-0846

---

Date of Request: ________________________

Member Name: ______________________________ DOB: _____________________________

Paramount Member ID#: _______________________ Paramount Secondary ID#:____________________
(if applicable)

Ordering Physician: ___________________________ Contact Person: ___________________________

Phone #: ____________________________________ Fax #: _________________________________

NPI: ______________________________________ Provider Billing Tax ID (TIN): ________________

ICD-10: _____________________________________

CPT Code(s): _________________________________

Description of Procedure/Testing: ____________________________________________________________

Continuation of Care Request (Concurrent Review): Yes: _____ No: ______.

If yes, please include previous authorization approval number: _______________________________

Solid Organ Transplant Request Yes ___ No ___

Date of Procedure/Testing: ___________________

Name of Facility: _____________________________ Address: _________________________________

Telephone Number: _______________________ Fax Number: __________________________

NPI #: ___________________________________ Tax ID#_______________________________

Please send the following information

- Brief medical/clinical history
- Current signs and symptoms
- Results of any pertinent diagnostic testing

PLEASE NOTE: OHIO BENEFIT ADMINISTRATORS IS NO LONGER ABLE TO REVIEW FOR RETRO DATES OF SERVICE

CONFIDENTIALITY NOTICE: The documents accompanying this fax transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from is closing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure copying distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these document



© 2021 Ohio Benefit Administrators | 1.3198-A2.080321.KM