OUT OF PLAN Prior Authorization
Attn: Out-of-Plan Coordinator
Toll Free at (800) 891-2520
Fax: 567-661-0847

Date of Request: _____

Member Name: _____ DOB: _____

Paramount ID#: _____ Secondary Paramount ID#: _____
(If applicable)

Ordering Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

NPI: _____ Provider Billing Tax ID (TIN): _____

State Reason for going out of network: _____

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

If yes, please include previous authorization approval number: _____

Solid Organ Transplant: Yes ☐ No ☐

Date of Appointment or length of stay: _____

Requested Services: _____

CPT Code: _____ Diagnosis: _____

Out of Plan Physician Name and Specialty: _____

Physician NPI#: _____ Physician Tax ID#: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Out of Plan Facility Name: _____

Facility NPI #: _____ Facility Tax ID# _____

Address: _____

Telephone Number: _____ Fax Number: _____

Please send the following information:

- Brief medical/clinical history
- Current signs and symptoms
- Results of any pertinent diagnostic testing
- Referring physician's expectation of the out-of-plan referral
- Consult or treatment documentation from in-plan or approved out-of-plan specialist