## FirstCare Prior Authorization Request Form



(DME, Inpatient Notification, Medical Drug, OON Referral, Prior Authorization)

SECTION I — Subm	11221011												
Issuer Name: FirstCare Health Plan	suer Name: irstCare Health Plans		MEDICAL/ DME Phone: 800-884-4905 Fax: 800-248-1852		Mental Health/Substance Abuse Phone: 800-327-6943 Fax: 512-233-5949					Date:			
SECTION II — GEN	ERAL INF	ORMATIC	ON										
Review Type: No				nical Reason fo	or Urgency:								
Request Type: 🗹 In	nitial Requ	est  Ex	tensi	ion/Renewal/Ar	nendment [	Ov	er-The	-Benefit-	Limit	Prev. A	Auth. #:		
SECTION III MEN	ADED INE		. N.I										
SECTION III — MEMBER INFORMATION  Member Name:			N	Phone:	DOE	DB: Se			ex:  Male Female				
									OUX.	Jox.   Wale   Female			
Subscriber Name (if different):				*Member or Medicaid ID #: Group #:					:				
SECTION IV — PRO	OVIDER IN	NFORMAT	ION										
Requesting Provider							Ser	vice Pro	vider	or Fac	cility		
Name: Specialty:					Name: Acadian Ambulance			Specialty Ground Ambulance					
Ind. NPI: TPI:		TPI:			Ind. NPI: 1750676870				TPI:	31853	33201		
Group NPI: TIN:					Group NPI:1750676870			TIN:	30068	88582			
Address:							_	_					
Contact Name:						3720 Corley Ave. Beaumont, TX. 77701 Contact Name:							
Phone:	Phone: Extension:		Fax:		Phone:		Extension			Fax: 337-291-22		1-2271	
SECTION V — SER	VICES RE	QUESTE	D AN	ND SUPPORTII	NG DIAGNO	SES	3						
							Diagnosis Description					DX Code	
Planned Service	or Proce	edure	Cod	e Start Date	End Da	ite	Diagn	osis Des	cripti	ion		DA Code	
Planned Service	or Proce	edure	Cod	e Start Date	End Da	ite	Diagn	osis Des	cripti	ion		DA Code	
Planned Service	e or Proce	edure	Cod	e Start Date	End Da	ite	Diagn	osis Des	cripti	ion		DX Code	
Planned Service	e or Proce	edure	Cod	e Start Date	End Da	ite	Diagn	osis Des	scripti	ion		DA Code	
Planned Service	e or Proce	edure	Cod	e Start Date	End Da	ite	Diagn	osis Des	cripti	ion		DA Code	
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