ALTERWOOD ADVANTAGE
Quality Care. Better Health.

PART B MEDICATION REQUEST FORM

Please fax completed form and all supporting documentation to
410-801-5701

Please check the appropriate priority:	
□ Standard	**Please select the proper review type:** □ Pre-Service □ Post-Service
□ Expedited *(pre-service only; post-service requests do not qualify for expedited review)*	
I certify that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.	
Provider Signature Required: _____	

Member Information:			
First Name:	Last Name:	Date of Birth:	Member ID:

Provider Information: Please complete all sections in full.		
	Requesting Provider	**Servicing Provider**
Name:		
NPI:		
Address:		
Phone:		
Fax:		

Facility Information: Please enter the information for where services will be rendered.	
Name:	
NPI:	
Address:	
Phone:	
Fax:	

Services Requested: Please check the appropriate service.			
Start Date:	End Date:		
Diagnosis Code(s):			
Diagnosis Code Description(s):			
CPT/HCPCS Code(s):	CPT/HCPCS Code Description(s)	Dosage/Number of Units	Frequency/Total Number of Treatments

This authorization does not guarantee payment of claim. All authorizations are subject to eligibility requirements and benefit plan limitations. ***Services are not considered authorized until Alterwood Advantage issues an approval.*** For a list of services that require PA or if you need to speak to a Utilization Management Representative, please call 667-262-9429 or toll free at 1-866-274-3265.