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ELECTIVE INPATIENT AND OUTPATIENT PRIOR AUTHORIZATION FORM

From: (Provider) _____ (Sender) _____ Phone: _____ Fax: _____ Date: _____	To: OSU Health Plan Phone: 614-292-4700 Fax: 614-292-2667
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NOTE: *A benefit reduction of 20 percent applies if preauthorization is not obtained at the time of service*

1. Patient Name:	2. DOB:	3. Member ID #:	4. Group #:	5. Member Phone #:
6. Physician*:	7. Selected Hospital*: The Ohio State University Hospital Other: _____			
8. Date of Service:	9. Diagnosis: ICD-9: ICD-9: ICD-9:		10. Diagnosis Description:	

* Services must be provided in-network if member is on a plan with no out-of-network benefits.

Procedure(s):

CPT:	Description:	# of units:

Prior Authorization #: _____	Days Authorized: _____
Authorized by: _____	Contact #: _____
Date: _____	

IMPORTANT MESSAGE

This message is intended for the use of the individual to which it is addressed. It may contain information that is privileged, confidential, and exempt from disclosure under law. If the reader of this message is not the intended recipient, or employee, or agent responsible for delivering the message to the intended recipient, you are notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

If you have received this communication in error, please notify the sender and destroy or delete this communication immediately. Thank you.

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