COMMON GROUND
HEALTHCARE COOPERATIVE

Fax completed form to Optum at:
877-251-0387

PRIOR AUTHORIZATION

To avoid delay in processing your request, please fill out this form completely.

I: PHYSICIAN OR OTHER HEALTHCARE PROVIDER

Requesting Provider Last Name	Requesting Provider First Name		Provider Tax ID
Provider Street Address	City	State	ZIP Code
Contact Name		Contact Phone Number	
Name of Facility			
Facility Street Address	City	State	ZIP Code
Anticipated Date of Service	Type of Service ❍ Inpatient ❍ Outpatient		

II: PATIENT INFORMATION

Member Last Name	Member First Name	Member ID
Patient Last Name	Patient First Name	Patient Date of Birth

III: SERVICE DESCRIPTION

Description of service

Diagnosis Codes	CPT/HCPCS
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____

IV: ADDITIONAL INFORMATION

NOTE: Please fax any documentation that will clarify your request with this form. Examples include:

- Test results (i.e., lab, visual fields, radiology, sleep study, etc.)
- Patient's current condition (i.e., height, weight, etc.)
- Pertinent history/evaluation(s)
- Progress notes

QUESTIONS? Call 877-450-8497