

☐ Routine Pharmacy-Injectable/Infused Medications (72 hours)

## Request for Authorization

Use this form for any service on the Brown & Toland Prior Authorization List and all out-of-network services. Fax to: Brown & Toland Referral Services at 415-972-6012 For eligibility confirmation or authorization status, call Referral Services at 800-225-5637

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For Internal Use Only: Authorization for payment of service is subject to member's eligibility and benefits on the date of service.						Expected/D.O.S	
Requesting Phy	NPI #:			Direct Phone #:			
Specialty:	alty: Office Contact:					Fax #:	
PCP:	Fax#:					Direct Phone #:	
Patient Informa	tion: D.O.B:		Sex:	M	F	Phone#:	
Name:			Address:				
Request Type: Admission Ambulatory/ Outpatient Surgery Diagnostic Testing DME/Orthotic/Prosthetic Home Care Outpatient Rehab Outpatient Office Services Referral Transplant Vaccines Drugs: □In-Office Admin □Outpatient Infusion □Self-Administered							
Facility/Agency:			NPI #:				
Address:				<u> </u>			
Provider of Service:			NPI #:				
Specialty:							
Surgical Assistant?	Yes	No	Name of Assista	ant:			
ICD-10 (REQUI	RED):						
ICD-10: m17.31	Diagn	osis:					
ICD-10:	Diagn	osis:					
ICD-10:	Diagn						
ICD-10:	Diagnosis:						
CPT/HCPCS Code (REQUIRED):							
CPT/HCPCS Code:		Units:	Descr	iption:			
CPT/HCPCS Code:		Units:		iption:			
CPT/HCPCS Code:		Units:	Descr	iption:			
CPT/HCPCS Code:		Units:	Descr	iption:			
Drug Name:	Dosage:	Met	hod of Delivery:		F	req/Duration:	
						ATION WITH <u>ALL</u> REQ PROCESSING OF TH	
Clinicals in EMR?	Yes No	If yes speci	fy date:				
	<del> </del>	<del> </del>	<del> </del>				