## **Prior Authorization Request Form**

| Patient Name                 |
|------------------------------|
|                              |
| Date of Birth                |
|                              |
| Member ID                    |
|                              |
| Provider Name                |
|                              |
| Provider Phone               |
|                              |
| Provider NPI                 |
|                              |
| Request Type                 |
| Thurston.                    |
| Urgency   ▼                  |
| Diagnosis/ICD Code           |
|                              |
| Procedure/Service            |
|                              |
| CPT/HCPCS Code               |
|                              |
| Clinical/Medical Rationale   |
|                              |
| Comparing Decomparate in a   |
| Supporting Documentation     |
| Choose File No file selected |