JAI MEDICAL SYSTEMS
301 INTERNATIONAL CIRCLE ▪ HUNT VALLEY, MARYLAND 21030 ▪ TELEPHONE 410.433.2200
FAX 410.433.8500 ▪ TOLL FREE 1.888.JAI.1999

STANDARD PRIOR AUTHORIZATION REQUEST FORM

Valid for 90 days from approval date

Instructions: Please complete all sections of this form and attach all related clinicals and supporting documentation for the request. Requests must be submitted via fax to 410-433-8500. Please note, incomplete submissions will ***not*** be processed.

For any questions, please contact the Utilization Management Department by phone at 410-433-5600.

Type of Service: Inpatient ☐ Outpatient ☐
Type of Request: Standard ☐ *Urgent ☐

Urgent requests are for services required to avoid serious deterioration of health and/or risk to life.

Member Information	
Member Name (Last, First):	Date of Birth:
Member MA Number:	Member Phone Number:
Member Address:	City, State, Zip:

Requesting Provider Information	
Requesting Provider Name:	NPI:
Organization Tax ID:	Organization Name:
Address:	City, State, Zip:
Phone Number:	Fax Number:

Place of Service/Service Provider	
Name of Place of Service:	Name of Servicing Provider:
NPI:	Tax ID:
Address:	City, State, Zip:
Phone Number:	Fax Number:

Procedure/ Service Requested *	
Date of Service/ Appointment Date:	Number of Visits:
ICD 10 Diagnosis Code:	ICD 10 Diagnosis Code Description:
CPT/HCPCS Code:	CPT/HCPCS Description:

Member Primary Care Provider (PCP) Information	
NPI:	Tax ID:
Address:	City, State, Zip:
Phone Number:	Fax Number:

PCP Name: (Print)_____Signature: _____Date: _____

Submission of a request to the UM Department does not constitute approval or any guarantee of approval for the requested procedure or service. Further, all requests and approvals are limited to benefits covered under the HealthChoice Program and subject to Member Eligibility on the Date of Service