JAI MEDICAL SYSTEMS

301 INTERNATIONAL CIRCLE • HUNT VALLEY, MARYLAND 21030

STANDARD PRIOR AUTHORIZATION REQUEST FORM

Valid 90 days upon approval

Utilization Review and Case Management - Telephone: 410-433-5600 Fax: 410-433-8500

Select One: **Standard Request_____** **Urgent Request_____** **Date Request Received_____**

Member Information	
Member Name:	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:

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

Diagnosis	
ICD-10 Code(s) / Brief Patient History:	Description:

Procedure(s) / Service(s)	
Nutritional Supplement: yes / no (circle one) – Sole source of nutrition: yes / no (circle one)	
CPT/HCPCS Code(s):	Description:

Start Date:	Number of Visits:	Appointment Date(s):
Inpatient / Outpatient (circle one)	**If left blank, 1 assumed**	

PCP Signature_____Date_____

Enclosed: Clinical and other supporting documentation including DME form(s), if applicable