



**Prior authorization supporting documentation cover sheet**

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**Fax:** 1-855-402-1684  
1-253-627-4708 (SNF and Inpatient)  
**Phone:** 1-877-836-6806  
1-253-627-4113 (Clinical Team for SNF)

Requestor contact: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Fax: \_\_\_\_\_

**IMPORTANT: Complete all fields on this form to ensure timely review.**

**Supporting documentation for existing prior authorization requests**

Attach clinical information to support prior authorization request (e.g., plan of care, medical records, lab reports, letter of medical necessity, progress notes, etc.).

**Case ID:** \_\_\_\_\_

**Patient name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Comments:**

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

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