Providence Health Plan | POWERED BY Collective Health

Request for prior authorization (precertification)

Please fax this completed form to: **866-881-9643**.

Requestor information	
Name:	Date submitted:
Phone number:	
Subscriber information	
Subscriber ID number:	Group number:
Name:	Date of birth:
Address:	Phone number:
Employer name:	Network name:
Patient information	
Name:	Date of birth:
Relationship to subscriber:	
Case information	
Setting: ☐Inpatient ☐Outpatient	Urgency: ☐Elective ☐Emergent
Case type:	
Admission date / EDC:	Procedure date:
Primary diagnoses:	Secondary diagnosis:
Procedure:	
Hospital information	
Name:	Phone number:
Mailing address:	
Physician information	
Name:	Phone number:
Specialty:	National Provider Identifier (NPI) or Taxpayer Identification Number (TIN):
Mailing address:	