LHV

LOWER HUDSON VALLEY E.A.P

Mental Health & Substance Use Disorder Services

Prior Authorization Request: Inpatient or Outpatient

Individual•s name:	Date of birth:
Member ID number:	Individual•s phone number:
Ordering provider•s name and specialty:	Provider NPI:
Office address:	
Office phone number:	Office Email:
Rendering provider•s name and specialty:	Provider NPI:
Office address:	
Office phone number:	Office fax number:
Facility name:	Facility NPI:
Facility address:	
Date range of service / Total days requested:	
Service requested (include CPT code(s):	
Diagnosis code(s):	
Place of service: ☐Home ☐Inpatient ☐Outpatient ☐Other_____	

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

_____ _____

*Name and Title of Provider or Provider Representative Completing Form And Attestation (Please Print)

*Date

***The attestation fields must be completed by a provider or provider representative in order for the request to be accepted.**