Prior Approval Form

Please print with black ink or fill in using Adobe® Reader. For a list of medications and services requiring prior approval or considered investigational, visit the Prior Approval Resources section of MedMutual.com/Provider.

1. Patient Information			
Patient Name (Last, First)	Birthdate (MM/DD/YYYY)	Today's Date	
Street Address	City	State	ZIP Code
Identification No.	Group No.	Daytime Phone	

2. Provider Information			
Provider Name (Last, First)	Phone Number	Fax Number	
Mailing Street Address	City	State	ZIP Code
Requester/Title (if different than prescriber)		Phone Number	
Provider Signature	Provider ID No.	Date	

3. For Genetic Testing—Lab Performing Test			
Provider Name (Last, First)	NPI No.	Z Code	
Mailing Street Address		Phone Number	
City		State	ZIP Code

4. Reason for Prior Approval

☐ Procedure
☐ Durable Medical Equipment (DME)
☐ Device
☐ Medication–Injectable and Infusion (Complete section 6 only)
☐ Genetic Test
☐ Out of Network Waiver
☐ Other–Describe

Description of Services (Please specify exact services being requested.)	
Diagnosis	ICD-10-CM Diagnosis Code(s)
	Is this an established diagnosis for the patient? ☐ Yes ☐ No
CPT/HCPCS Code(s)	Name and place of service ☐ Office ☐ In/Outpatient Facility ☐ Home ☐ SNF ☐ Other–Describe:
Is there previous history of services relating to this prior approval? ☐ Yes ☐ No If yes, please describe:	

5. Medical Necessity Statement and Documentation

The following documentation is enclosed for review of this prior approval request.
☐ Office Notes ☐ Medical Records ☐ X-rays ☐ Photos ☐ Other–Describe:

6. Medication Prior Approval (Please complete one form per medication being requested)

Complete this form for an injectable or infusion being requested under the member's medical benefit, i.e., non self-administered injectables. If the medication is self-administered, contact the member's pharmacy benefit manager to determine prior authorization requirements.

Requested Medication

☐ New Request (Proceed to Diagnosis below)
☐ Renewal of previous approval (If renewal, explain how efficacy has been determined)

Diagnosis

ICD-10-CM Diagnosis Code(s)	Weight (lbs.)	Height

Dose	Frequency	Route

CPT/HCPCS Code	NDC

Place of Service ☐ Office ☐ Outpatient Facility ☐ Infusion Center ☐ Pharmacy ☐ Other–Describe:

Medical Necessity (clinical and treatment history). Include medications adverse effects and conditions.

The following documentation is enclosed for review of this prior approval request.
☐ Office Notes ☐ Medical Records ☐ Other–Describe:

Fully completed forms can be submitted to Medical Mutual via the following:

For Medicare Advantage	**For Commercial Services**
Contracting Providers Via Cohere Portal (login.coherehealth.com)	Contracting Providers Via Cohere Portal (login.coherehealth.com)
Non Contracting Providers Fax: 1-800-221-2640	Non Contracting Providers Fax: 1-877-321-6664

Fax medical drugs (drugs usually administered by a healthcare professional and billed under the medical benefit) prior approval requests to Magellan Rx at 1-888-656-1948.