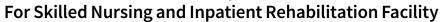
Prior Authorization Request





All Skilled Nursing requests require prior authorization for service (s) to be rendered.

Instructions for Completing this Request

 $Submit this completed form to MVP Health Care ``via email to {\it authorization request@mvphealthcare.com} \ or fax it to {\it 1-866-942-7826}.$

All supporting medical documentation and/or any additional pertinent information should be included when submitting this form.

Payment for services/items dispensed will be denied when prior authorization is not obtained. The Member may not be billed under these circumstances.

| Section 1: MVP Member Information (*Required Information) | | | | | | | |
|---|--------------|---------------------------------|-----------------|--------------|----------------------|----------------------------|--|
| Member Name* | | Date of Birth* | MVP Member ID N | nber ID No.* | | Vermont Resident?* Yes No | |
| Section 2: Facility and Physic | | | | (*R | equired Information) | | |
| Servicing Facility* | | Tax ID No. | Tax ID No. | | NPI | | |
| Office Street Address* | | City* | City* | | State* | Zip Code* | |
| Contact Name* | | Phone No. | Phone No. | | Fax No. | | |
| Requesting/Attending Physician Name | | Tax ID No. | Tax ID No. | | NPI | | |
| Office Street Address* | | City* | City* | | State* | Zip Code* | |
| Phone No.* () | Fax No.* () | | | | | | |
| Section 3: Diagnosis Information Diagnosis* | | Existing Reference No. (if any) | | | | | |
| Service Requested* Skilled Nursing Facility Inpatient Rehab Facility | | | | | | | |
| Special Notes | | | | | | | |
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