

<p>This standard form should be utilized to submit prior authorization request to VCMAX along with the necessary clinical documentation to support the request. Incomplete submissions will be returned unprocessed. If you have any questions, please call 800-469-6292.</p>		
<p>Expedited Request: Please check if you believe a delay of service could seriously jeopardize the life or health of the member or ability to regain maximum function in serious jeopardy.</p>		
MEMBER INFORMATION		
Last Name	First Name	
Member ID	DOB	
PROVIDER INFORMATION		
Check One: You are the Prescribing/Ordering Referring		
Name	TAX ID	NPI #
Provider Address		
Phone	Fax	Email
Contact Person	Phone	Fax
Check One: You are the Requesting Provider Servicing Provider		
Name	TAX ID	NPI #
Provider Address		
Phone	Fax	Email
Contact Person	Phone	Fax
CLINICAL INFORMATION		
Member Symptoms and Duration		
Summary of Clinical Findings		
Order Description		
Medical Justification		
Diagnosis		
SERVICE TYPE REQUIRING AUTHORIZATION		
Place of Service		
Start Date of Service		End Date of Service
Order Date	Quantity Requested	Time Requested
Ambulatory/Outpatient Services	Inpatient Care	Outpatient Services
Surgery/Procedure Infusion or Oncology Medications	Acute Inpatient Admission Short Term/Acute Rehab Skilled Nursing Facility	Physical Therapy Occupational Therapy Speech Therapy
Home Health Services	Ancillary Services	Durable Medical Equipment
Home Health Please circle: SN,PT,ST,MSW Hospice Infusion Therapy Respite Care	Acupuncture	Prosthetic Device Enteral Supplies Incontinence Supplies Medical Supplies Purchase Rental

Please attach clinical documentation to support the request. I.e. clinical notes, lab results, x-rays etc. Durable Medical Equipment requires a physician signed prescription and letter of medical necessity.