



Pre-Authorization Request Form

All procedures or health care services requiring pre-authorization should be faxed or mailed to MVP's Corporate Utilization Management department before services are rendered.

This form and any supporting medical documentation (lab, radiology, consultation reports, office notes, etc.) must be faxed or mailed to:

For MVP Select Care (ASO) members:

PO Box 1434, Schenectady, NY 12305

Fax 518-386-7764, Telephone 1-800-229-5851

For all other MVP members:

625 State Street, Schenectady, NY 12305

Fax 1-800-280-7346, Telephone 1-800-568-0458

For urgent requests (clinical emergencies), please call the Utilization Management department.

Service requested is not a covered benefit by MVP, until, or unless, MVP reviews and grants pre-authorization for the service. The patient must be advised that without pre-authorization by MVP for this service, the patient may be required to pay out-of-pocket for services rendered.

Patient name _____	Referred to physician/facility _____
Date of birth _____	Address _____
MVP ID # _____	_____
Does COB apply? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone number _____
If yes, please specify COB _____	Fax number _____
Requesting physician name _____	Is Provider in MVP's network? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address _____	Diagnosis _____
Office contact name _____	ICD-9 Code(s) _____ CPT Code(s) _____
Phone number _____	Procedures/services requested _____
Fax number _____	_____
Requesting physician signature _____	Services to be performed: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office
Date of Service _____	ATTACH ALL SUPPORTING MEDICAL DOCUMENTATION TO FAX

Please note: For MVP members enrolled in an EPO or PPO plan, it is the member's responsibility to call MVP to provide prior notification. Participating providers can, but are not responsible for, calling MVP to provide pre-service notification.