Prior Authorization Request Form

All procedures or health care services requiring prior 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 noted, etc.) must be faxed or mailed to:

For all MVP members (except ASO):
625 State Street
Schenectady, NY 12305
Fax 1-800-280-7346
Telephone 1-800-568-0458

For MVP Select Care (ASO) members:
PO Box 1434
Schenectady, NY 12305
Fax 1-800-280-7346
Telephone 1-800-229-5851

For Vermont Managed Care:
PO Box 1150
Burlington, VT 05402
Fax 802-847-6213
Telephone 1-800-639-3881

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

Services requested are not a covered benefit by MVP, until, or unless, MVP reviews and grants prior authorization for the service. The patient must be advised that without prior 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? ☐ Yes ☐ No	Phone number_____
If yes, please specify COB_____	Fax number _____
Requesting physician name _____	Is Provider in MVP's network? ☐ Yes ☐ No
NPI # _____	Diagnosis_____
Address _____	ICD-9 Code(s) _____
Office contact name _____	CPT Code(s) _____
Phone number_____	Procedures/services requested _____
Fax number _____	_____
Requesting physician signature _____	Services to be performed: ☐ Inpatient ☐ Outpatient ☐ Office
Date of Service _____	**ATTACH ALL SUPPORTING MEDICAL DOCUMENTATION TO FAX**