

## Behavioral Health Outpatient Prior Authorization Form

Fax completed form to 570-214-3573.

All required fields (\*) must be completed. Incomplete forms will be returned unprocessed.

**Still faxing?** If so, you may be missing out on timesaving benefits, including automatic approvals and guided submission only available when using the Cohere portal to manage authorizations. Registration only takes a few minutes and unlocks access for all users at your practice organization.

Visit [www.coherehealth.com/register](http://www.coherehealth.com/register) to begin.

Date of Request: (mm/dd/yyyy)		*Member Name:	
Member Medical Record #:		*Member DOB:	*Member ID:
*Contact Person:		*Contact Phone:	Ext:
*Requesting Provider Name	*Requesting Provider NPI:	*Requesting Provider Phone:	
	*Requesting Provider TIN:	Requesting Provider Fax:	
*Servicing Provider Name	*Servicing Provider NPI:	Servicing Provider Phone:	
	*Servicing Provider TIN:	Servicing Provider Fax:	
*Facility/Location of Service Name:	* Facility/Location of Service NPI:	Facility Phone:	
	* Facility/Location of Service TIN:	Facility Fax:	
Facility/Location Address:			
*Requested Service:		*Procedure Code(s):	
Any services performed through telehealth? <input type="radio"/> Yes <input type="radio"/> No			
*Anticipated Dates of Service: (from/to)			
How many sessions:	Frequency (biweekly, weekly, etc.):	*Total # of sessions requested:	
Diagnosis:		*Diagnosis Code(s):	
Clinical information:			
* Person Submitting Request Name:		*Person Submitting Request Phone:	

Attach supporting documentation to aid in processing. Authorization verifies medical necessity criteria have been met and is not a guarantee of payment.