Behavioral Health Outpatient Prior Authorization Form

Fax completed form to 570-214-4539.
All required fields (*) must be completed. Incomplete forms will be returned unprocessed.

Date of Request: (mm/dd/yyyy)	*Member Name:		
Member Medical Record #:	Member DOB:	Member ID:	
*Contact Person:		*Contact Phone:	Ext:
*Requesting Provider:		*Requesting Provider Phone:	
		*Requesting Provider Fax:	
Servicing Provider Name:		Servicing Provider Phone:	
		Servicing Provider Fax:	
*Facility/Location of Service:		Facility Phone:	
		Facility Fax:	
Facility/Location Address:			
*Requested Service: Any services performed through telehealth? Yes ◯ No ◯		*Procedure Code(s):	
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.