MARVIX AI

PRIOR AUTHORIZATION LETTER TEMPLATE

Questions? Visit us at www.marvix.ai

1 PATIENT INFORMATION

PATIENT NAME

DATE OF SERVICE

DOB

INSURANCE / PAYER

AGE / SEX

MEMBER ID

MRN / PATIENT ID

GROUP NUMBER

POLICY NUMBER

2 PROVIDER INFORMATION

PROVIDER NAME

NPI

CREDENTIALS

TAX ID

SPECIALTY

PHONE

PRACTICE / FACILITY NAME

FAX

ADDRESS

3 RECIPIENT / PAYER INFORMATION

INSURANCE COMPANY / PAYER NAME

PHONE

PRIOR AUTHORIZATION DEPARTMENT

FAX / PORTAL SUBMISSION

ADDRESS

4 REQUESTED SERVICE / TREATMENT

REQUESTED MEDICATION / PROCEDURE / SERVICE / DEVICE

DOSE / STRENGTH / QUANTITY / FREQUENCY, IF APPLICABLE

ROUTE OF ADMINISTRATION, IF APPLICABLE

DURATION OF TREATMENT

PLACE OF SERVICE

REQUESTED START DATE

5 DIAGNOSIS INFORMATION

PRIMARY DIAGNOSIS

ICD-10 CODE

SECONDARY DIAGNOSIS, IF APPLICABLE

ICD-10 CODE

6 CLINICAL SUMMARY

Reason for Request:

Relevant History:

Current Symptoms / Functional Limitations:

Disease Severity / Clinical Status:

7 PRIOR TREATMENTS / FAILED THERAPIES

Medication / Treatment Trial 1:

Medication / Treatment Trial 2:

Medication / Treatment Trial 3:

Reason for Discontinuation / Inadequate Response:

8 MEDICAL NECESSITY RATIONALE

Clinical indication for the requested service, applicable guideline or coverage criteria supporting the request, the risk to the patient of delay or denial, and the expected clinical benefit of the requested treatment...

9 SUPPORTING DOCUMENTATION

PROGRESS NOTES

PRIOR AUTHORIZATION FORMS

LAB RESULTS

SPECIALIST RECOMMENDATIONS

IMAGING REPORTS

THERAPY NOTES

PROCEDURE REPORTS

OTHER ATTACHMENTS

10 REQUESTED DETERMINATION

AUTHORIZATION REQUESTED

REQUESTED APPROVAL PERIOD

URGENCY LEVEL (STANDARD / EXPEDITED)

CONTACT FOR ADDITIONAL INFORMATION

CS CLOSING STATEMENT

Provider Request for Approval:

Follow-Up Contact Information:

SO **SIGNATURE**

PROVIDER NAME	CREDENTIALS	SIGNATURE	DATE	TIME