



## HOW TO USE THIS FORM:

- Complete** all required fields marked with an **asterisk (\*)**. Incomplete forms may be delayed unless all required information is received.
- Attach** copies of supporting clinical information. Required clinical documentation is listed on our website: <https://preauth.cloverhealth.com/en/pre-auth-request>
- Fax** this form to 1-833-866-2893
- Call** us with questions, 1-800-932-7013 to chat with our Utilization Management dept.

### MEMBER INFORMATION (please print clearly)

Member Name *	Member ID *	Date of Birth * ____/____/____ (MM / DD / YYYY)
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REQUESTING PROVIDER / FACILITY INFORMATION			RENDERING PROVIDER / FACILITY INFORMATION		
Requesting NPI (Provider or Facility) *			Rendering NPI (Provider or Facility) * <input type="checkbox"/> Same as Requesting Provider		
Requesting MD/Facility Name *		Provider Specialty	Rendering MD/Facility Name *		Provider Specialty
Address *			Address *		
City *	State *	ZIP Code *	City *	State *	ZIP Code *
Contact Name (Title/Dept)			Contact Name (Title/Dept)		
Phone *	Fax *		Phone *	Fax *	

### REQUEST DETAILS

<input type="checkbox"/> New Start		<input type="checkbox"/> Continuation of Therapy	
Drug Billing Code (HCPCS)	Medication Name *	Dose & Frequency *	
Route of Administration (IV, IM, SC, ETC.)	Start Date * ____/____/____	End Date ____/____/____	
<b>Place of Service *</b> <input type="checkbox"/> Ambulatory Surgical <input type="checkbox"/> Off Campus Outpatient Hospital <input type="checkbox"/> Pharmacy <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> On Campus Outpatient Hospital		<b>Place of Drug Dispense *</b> <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Pharmacy	

**Diagnosis (ICD-10) \***

Additional clinical information  
(Please attach clinical chart notes documenting diagnosis, medication history with response to therapy and any additional supporting documents for request)

Medicare requests are processed within a 72-hour standard timeframe. If the standard 72-hour timeframe would seriously jeopardize the life or health of the member, an urgent review can be requested and processed within 24 hours  <input type="checkbox"/> <b>URGENT REQUEST:</b> By checking this box, I certify that applying the 72-hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.	Total Pages:
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