



Curative Medical Prior Authorization Form

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https://curative.com/priorauth

Please allow 3 business days after submitting your request to receive a determination for outpatient services and 1 day for ongoing inpatient requests.

All fields are required for processing unless marked as optional. Failure to do so will cause your request to be returned unprocessed.

Form with fields: Today's Date, Office Contact Name, Phone, Fax

Member Information

Form with fields: Name, Phone, DOB, Gender (Male/Female/Other/Unknown), Member ID, Request Type (Outpatient, Inpatient, Day Surg, OT/PT/ST, DME, Imaging, Home Health, SNF, LTAC, Infusion, IOP, IP Detox, Office Procedure, Transplant)

Requesting Provider

Form with fields: Name, Address, City, State, Zip, Phone, Fax, Provider NPI#, Provider Federal Tax ID#

Servicing Provider/Facility

Form with fields: Name of Facility & Address, Scheduled Service Date, City, State, Zip, Provider NPI#, Provider Federal Tax ID#, Description of Procedure & CPT or HCPCS(S) Codes, Diagnosis / ICD 10 Codes, and a mandatory note: \*\*\*\*All requests must include pertinent clinical/progress notes or provide clinical narrative, including duration of problem, types of treatment, step therapy attempts pertinent physical findings, pertinent testing results including but not limited to lab, imaging, and/or supporting specialty consultations.

Pertinent Medical Records included: [ ] Yes [ ] No

Coordination of Benefits (Other Insurance)

Form with fields: Other Insurance Coverage (Yes/No), MVA Subrogation (Yes/No), Date of Injury (optional), Workman's Compensation (Yes/No), Name of Insurance (optional), Subscriber Name & ID# (optional)

All medical services requested are subject to review, which includes but is not limited to, medical necessity review, determination of eligibility in accordance with the terms of the participant's benefit plan, any deductibles, co-pays, co-insurance percentages, reasonable and customary charges, and policy maximums.

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