



MEDICAL ASSOCIATES  
HEALTH PLANS\*  
Prior Authorization Form

Fax: 563-585-1545  
Telephone: 563-584-3275 or 1-800-325-7442

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Physician: \_\_\_\_\_  
(May also affix patient label for patient identification)

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Diagnosis and Dx. Code: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Date of Appointment: \_\_\_\_\_  
Specialty To Which Referred: \_\_\_\_\_  
Comments: \_\_\_\_\_

Reason for referral: Please place check by what applies:  30 days  60 Days  90 Days  \_\_\_\_\_

- Second Opinion Only
- Consultation Only
- Consultation to include Diagnostic Testing
- Treatment /Medical/Surgical
- Surgery  Inpatient  SDS
- Outpatient Follow-up
- PT  OT  Cardiac Rehab  Speech Therapy
- Chiropractic
- Other (please specify) \_\_\_\_\_

Please list what test results i.e. x-rays, labs the member will be bringing with them:  
\_\_\_\_\_  
\_\_\_\_\_

If for admission/SDS, please complete the following:  
Hospital/Facility Name: \_\_\_\_\_ Admission Date: \_\_\_\_\_  
Surgery: \_\_\_\_\_ Surgery Code: \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

Payment will only be made for the services listed on this referral authorization and paid according to the benefits set forth in your Subscriber Agreement. Any additional services ordered or received from this provider will not be covered unless prior authorization has been granted. You will be responsible for payment for any unauthorized services. Final determination of coverage will be based on the claim and is subject to the member's contract and limitations.

**Please take this form with you to the appointment.**