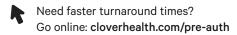
Clover

Pre-Authorization Request





- 1. Complete all required fields marked with an asterisk (*). Incomplete forms may be delayed unless all required information is received.
- 2. **Attach** copies of supporting clinical information. Required clinical documentation is listed on our website: cloverhealth.com/pre-auth-list
- 3. **Fax** this form to 1-800-308-1107

MEMBER INFOR	MATION (please print c	learly)							
Member Name*		Member ID*				Date of Birth* /			
REQUESTING PI	ROVIDER / FACILITY INI	FORMATI	ON				,		
Requesting NPI (Provider or Facility)*					Requesting Contact Name				
Requesting MD/Fa					Title/Dept.				
Address*					Email				
City*		State*		ZIP co	ode*	Phone		Fax	
SERVICING PRO	VIDER / FACILITY INFO	RMATION	1						
Servicing NPI (Provider or Facility)* Same as requesting Provider or Facility						Servicing Contact Name			
Servicing MD/Faci	Specialty*				Title/Dept.				
Address*						Email			
City*		State*		ZIP code*		Phone		Fax	
AUTHORIZATIO	N REQUEST (please atta	ach copies	s of re	quirec	d clinical c	locumentation)*	*		
Service Type* Inpatient Outpatient	Place of Service* ☐ MD Office ☐ Home ☐ Amg Surg. ☐ Other		lealth DME			Start Date or Admission Date*		End Date or Discharge Date	
Primary Procedure Code (CPT/HCPCS)		Unit(s)) Modifier		Diagnosi	s Code (ICD 10)*	Service Description		
Additional Procedure Code(s) (CPT/HCPCS)		Unit(s)	Modifier		Diagnosis Code (ICD 10)		Service Description		
URGENT REQUE	ST (If applicable, explain n	nedical nee	ed to ex	pedite	;*)				Total Pages:
	ocessed on a 14 calendar day timefi er's needs and no later than 72 hour								

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