PIEDMONT
INTERNAL
MEDICINE

Piedmont Internal Medicine

Medication Prior Authorization Request

Patient Name: ______________________________ **MRN/SSN:** __________________________

Date of Birth: ____________________ **Phone # (best reached):** _________________________

I, ________________________________ request Piedmont Internal Medicine, PC to obtain a prior authorization from my insurance for a prescription medication

Authorization Needed for:

Name of Prescription Medication (s): (please specify: name, quantity and dosage)

____

Insurance to Be Contacted:

Name of Insurance Company: ____

Member Identification Number: ____

PLEASE NOTE: Medication prior authorization initiation and completion time will be approximately 5-7 days depending on your insurance company.

Authorization:

By signing this form, I am acknowledging I will be charged an administration fee for completing the requested medication prior authorization. This fee will not be covered by my insurance and I will need to complete payment prior to the prior authorization being initiated. Additionally, I am aware the insurance may approve or deny this medication based on my insurance plan's guidelines. This associated fee does not include second level appeals or future reauthorizations.

Number of Authorizations	Fee Associated
1-2	$35.00
3	$40.00
4+	$50.00

Signature: ____Date:__________________________________

(Patient/Legally Authorized Representative)

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Information below this in line is to be shredded after processing

Name on Card: __________________________________ Credit Card Number: ____________________________

Expiration Date: ________________________________ CVS Number: ___________________________________

Charge Amount: ____