



Prior Approval Form

CONSUMERS LIFE INSURANCE COMPANY® | 1st MEDICAL NETWORK® | CAROLINA CARE PLAN®

NOTE: A listing of the **services requiring a prior approval** can be found on the Company Web site: MedMutual.com/ConsumersLife.com/CarolinaCarePlan.com. (See *Providers/Resources/Corporate Medical Policies*). You may also find the **Prior Approval Form** at the **same Web site**.

Patient Information	Name:	Date of Birth:	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Address									
	City	State				Zip Code				
	<input type="text"/>					<input type="text"/>				
Provider Information	I.D. Number: (12 digits)					Group Number: (5 or 9 digits)				
	<input type="text"/>					<input type="text"/>				

Provider Information	Provider Name:	Provider NPI Number:	<input type="text"/>							
	Address:									
	City	State				Zip Code				
	<input type="text"/>					<input type="text"/>				
Reason for Predetermination	Phone Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>									
	<small>Area Code</small>									

Reason for Predetermination	SERVICE TO BE RENDERED: (Describe) Be specific about the exact services, e.g., specify right, left, bilateral, partial, total, etc.									
	CPT Codes:					Diagnosis Codes:				
	<input type="text"/>					<input type="text"/>				
Medical Necessity Statement and Documentation	Is there a previous history of services relating to this prior approval service? <input type="checkbox"/> No <input type="checkbox"/> Yes if yes, please describe:									

Medical Necessity Statement and Documentation	The following documentation is enclosed for review of this prior approval request:									
	<input type="checkbox"/> Office notes <input type="checkbox"/> Medical records <input type="checkbox"/> X-rays <input type="checkbox"/> Photos <input type="checkbox"/> Other—Describe:									
	Provider Signature:					Date:				
	<input type="text"/>					<input type="text"/>				
Mail or fax this form with the Medical Necessity documentation to: Medical Mutual of Ohio/Consumers Life Insurance Company/Carolina Care Plan Medical Review Department (CC 3982) 2060 East Ninth Street, Cleveland, Ohio 44115-1355 Fax: 800/516-2583										