MEDICATION PREAUTHORIZATION REQUEST

Return this Form to: MPI: Medical Review • MedicalReview@mpiphp.org
Mail: P.O. Box 1999 • Studio City, CA 91614-0999

Provider Data			
Treating Physician or Provider Name (Required)		**Today's Date**	**# of Pages**
National Provider ID Number (Required)	**Tax ID Number (Required)**	**Contact Person**	
Address (Required)			**Location Code**
City		**State**	**Zip**
Email		**Phone (Required)**	**Fax (Required)**

Authorization Data		
Patient's Name	**Patient's Date of Birth**	**Subscribers SSN:**
Subscribers MPID Number	**Subscribers Name**	

☐ **New Request** ☐ **Renewal (if renewal, please provide original approval date):** _____

Diagnosis and ICD-10 Codes: (Required)

Medication requested / HCPCS Code(s) (Required)

Medication Name:	**HCPC Code:**	**Strength:**
Route:	**Frequency:**	**Duration:**

Please provide all relevant clinical information to support a Prior Authorization request review / Check all that apply:

- ☐ Letter of medical necessity
- ☐ Labs and X-Ray results
- ☐ Prescription from treating physician and or prior prescription documentation
- ☐ Consultant report with history and physical
- ☐ Progress notes
- ☐ Additional information requested from Motion Picture Industry Health Plan
- ☐ Other:

Provider Signature: _____ **Date:** _____