

**Required Information**  
Inquiries with incomplete information will be returned to the provider.

|   |                              |                                    |
|---|------------------------------|------------------------------------|
| <b>Patient Name (Last, First, Middle Initial)</b>               | Member Identification Number | Patient Date of birth              |
| <b>Certificate Holder Name</b><br>(Last, First, Middle Initial) | Patient's Sex                | Relationship to Certificate Holder |
| Address   | Diagnosis                    |                                    |
| City, State, Zip Code   | Diagnosis Code               |                                    |
| <b>Provider Name</b><br>(Last, First, Middle Initial)           | Providers Telephone Number   | Provider Fax Number                |
| Address   | Additional Comments:         |                                    |
| City, State, Zip Code   |                              |                                    |

**Internal Use Only**

**GBAS Document#** \_\_\_\_\_

**TRIM DCN:** \_\_\_\_\_

**Reason for Request – Check all that apply**

- Prior Approval Medical Surgical Procedure     DME  
 Prior Approval Drug                                     Other \_\_\_\_\_

**Note: \*\*\*THIS FORM IS NOT A SUBSTITUTE FOR A PRESCRIPTION**

**Details of Request**

**Please include CPT/HCPC Codes etc., Diagnosis and Diagnosis Code, Price, Anticipated date of service and Detailed Description of Service**

| Anticipated Date of Service | CPT/HCPC Codes | Description of Service |
|-----------------------------|----------------|------------------------|
| / /                         |                |                        |
| / /                         |                |                        |
| / /                         |                |                        |

I certify the accuracy and completeness of all information reported by me on this form.

Provider Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Supporting Documentation**  
Please attach the required documentation which may include:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>○ Office notes</li> <li>○ Physical medicine/chiropractic notes</li> <li>○ Operative report(s)</li> <li>○ HME (Home Medical Equipment)               <ul style="list-style-type: none"> <li>○ Include provider manufacturer's invoice if requesting additional allowance</li> </ul> </li> </ul> | <p><b>Pharmacy</b></p> <ul style="list-style-type: none"> <li>○ NDC Number</li> <li>○ Quantity</li> <li>○ Description of service/drug</li> </ul> |
|---|--|

\* See reverse side for definitions, helpful hints and address to send form to.

**Form & Document Submission:** This form can be emailed, faxed or mailed after completion.

- Email process: Click on submit form button this will open an email window, the completed prior approval form will automatically attach. At this point attach/insert the supporting documentation, prior to emailing this for review.

**Mail or Fax to:**

First Administrators, Inc.  
PO Box 9900  
Sioux City, Iowa 51102-0479  
Fax 712-279-8579

First Administrators, Inc.  
PO Box 8150  
Rapid City, SD 57709-8150  
Fax 605-399-7920

**Definitions**

*Reply Address* – The mailing address where the reply to this inquiry should be sent.

*Member* – The person whose name the health coverage is under.

*Member Identification Number* – The identification number listed on the member ID card. Ex:00000JD0000F

**Helpful Hints**

- Use one prior approval form per patient per issue.