Prior Authorization Form
Enteral Request

Phone: 1-800-521-6622 | Fax: 1-866-755-9841

AmeriHealth Caritas Pennsylvania

Contact name:

Phone number: Fax number:

Member information		
Member name:		Member ID number:
Date of birth:	Member's phone number:	
Authorization number, if applicable:		
Primary insurance? ☐ Yes ☐ No	Name of carrier:	
Primary insurer member ID:	Primary authorization number:	

Provider information		
Physician name:		Physician NPI:
Physician phone number:	Physician fax number:	
Vendor name:		Vendor NPI:
Vendor phone number:	Vendor fax number:	

Codes

Code	Formula	Order	Units per month	Billing amount

Enteral supply codes

Code	Supply description	Units per month	Billing amount

Enteral request information		
Diagnosis:		
Dates of service:		Sole source of nutrition: ☐ Yes ☐ No
Administration method: ☐ Pump ☐ Gravity ☐ Bolus ☐ Oral ☐ Other		
Route: ☐ G-tube ☐ N-G tube ☐ J-Jejunostomy? ☐ Low profile ☐ Other		
Height:	Weight:	Prealbumin:
Date last LOMN/script supplied:		Referred to WIC? ☐ Yes ☐ No

CLINICAL NOTES TO SUPPORT THE MEDICAL NEED OF THIS SERVICE ARE REQUIRED.

ALL FIELDS MUST BE COMPLETED FOR REQUEST TO BE PROCESSED.