COMMON GROUND
HEALTHCARE COOPERATIVE

Fax Completed Form To:
Common Ground Healthcare Cooperative (CGHC)
T: 877.825.9293 | F: 888. 656.6671

Medical Benefit Drug Prior Authorization Request

Date:

Member Information		
Member Name:	**SMID:**	**Date of Birth:** (MM/DD/YYYY)
Provider Information		
Provider Name:	**Phone Number:**	**Fax Number:**
Place of Service: ☐ Ambulatory Surgery Center ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Provider's Office ☐ Infusion Center ☐ Long-Term Care Center ☐ Member's Home ☐ Other:		
Facility where services will be provided: (include address if the provider provides services at more than one location)		
Contact Name:	**Phone Number:**	**Fax Number:**
Pharmaceutical Information		
Requested Pharmaceutical:	**Procedure Code:**	**Scheduled Date of Service:** (MM/DD/YYYY)

Diagnosis:	**Diagnosis Code(s):**
NDC Code(s):	**Dose and Strength:**
Frequency:	**Desired Length of Therapy:**
Route: ☐ IV ☐ SQ ☐ Other:	☐ **Formulary** ☐ **Nonformulary**

Previous Therapies Tried: ☐ Yes ☐ No If yes, please list:

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.
Provider signature: Date:

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.
Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Contact CGHC Member Services with any questions: 877.514.2442.